

CROYDON PRIMARY CARE TRUST'S COMMISSIONING STRATEGY PLAN 2008/2009 – 2012/2013

CONTENTS

SECTION 1 CHIEF EXECUTIVE'S FORWARD	3
SECTION 2 – VISION	5
2.1 The vision for Croydon	5
2.2 The core values	5
2.3 The vision for London.....	5
SECTION 3 – CONTEXT	7
3.1 Croydon Primary Care Trust	7
3.2 The local and national context.....	7
3.3.1 Joint Strategic Needs Assessment (JSNA)	9
3.3.2 Demographic trends	9
3.3.3 Croydon's local health profile.....	13
3.4 Insights from patients, public, clinicians and local partners.....	26
3.5 Existing targets and local and national health priorities.....	32
3.6 Provider landscape	34
3.7 Financial situation.....	43
3.8 Activity commissioned	47
3.9 Primary and community services strategy	48
3.10 Conclusion.....	51
SECTION 4 – STRATEGY: OUTCOMES, GOALS AND INIAITIVES	52
4.1 Outcomes.....	52
4.2 Strategic Goals.....	53
4.3 Initiatives.....	58
4.3 Overall impact	69
4.3.1 Overall impact on quality, health outcomes and inequalities.....	69
4.3.2 Overall impact on activity.....	73
4.3.3 Overall impact on finance.....	74
4.3.5 Overall impact on consultation.....	78
4.3.6 Overall impact on the provider landscape.....	80
SECTION 5 – DELIVERY	83
5.1 Past delivery performance summary	83
5.2 Capabilities summary	85
5.3 Risk management summary.....	87
5.4 In-year monitoring and progress management summary.....	90
5.5 Enabling strategies summary	96
5.5.1 Strategic financial management to secure sustainable surplus	96
5.5.2 Market management and procurement strategy	96
5.5.4 Workforce strategy.....	98
5.5.5 Communications Strategy.....	99
5.5.6 Patient and public involvement strategy	99
5.5.7 Estates Strategy	100
5.5.8 IM&T Strategy	101
SECTION 6 – DECLARATION OF BOARD APPROVAL	103

SECTION 1 CHIEF EXECUTIVE'S FORWARD

Croydon PCT aims to enable the people of Croydon to improve their health. Our vision is to ensure:

- Communities and individuals can make informed choices about their health and health care
- Whereby they can maximise their health and well being
- They are supported by high quality services which are responsive to the needs of individuals and which do not unnecessarily disrupt their daily lives
- Where inequalities in health and health services are tackled

This Commissioning Strategy Plan sets out the PCT's goals for the next five years and the initiatives through which we will deliver them. It builds on the strengths of the PCT and also recognises the scale of the changes we need to make in order to significantly improve health and tackle inequalities. The PCT will continue to work in close partnership with colleagues in the statutory, voluntary and business sectors to achieve its goals. It will contribute, through the Local Strategic Partnership to developing the vision for Croydon over the next 20 to 30 years. The PCT's strategy reflects Croydon's sustainable Community Strategy and the Local Area Agreement.

The PCT also makes an active contribution to the wider NHS which is reflected in the South West London Collaborative Commissioning Initiatives (CCIs). In turn the CSP reflects the London and South West London context and particularly the strategic framework of Healthcare for London, and the London Narrative of the Government Office for London.

Croydon is the largest London borough, with a growing population which is increasingly diverse. The development of the CSP has been driven by the Joint Strategic Needs Assessment, and other local work on local needs, particularly the annual reports of the Director of Public Health. It reflects wide engagement from stakeholders and local people, through a wide range of activities. It has been developed through the active leadership of the Board and the Professional Executive Committee, with significant engagement from practice based commissioners and other clinicians with particular interests and expertise. The Communication Strategy and the Patient and Public Involvement Strategy will further develop our engagement and consultation with our communities, patients, staff and partners.

Last year's Commissioning Strategy Plan began to set out our strategy and has been used as the framework for Practice Based Commissioning Plans. This plan builds on that work and reflects a number of recent developments. The goals and initiatives have been reviewed and revised to:

- focus on the delivery of longer term outcomes, reflected in key indicators,
- deliver the programmes of the Next Stage Review and Healthcare for London
- support the delivery of the South West London Collaborative Commissioning Initiatives (CCIs) - which need commissioning over a bigger population than that of a single health community.

Responding to these wider strategies and the feedback from local people we have added two goals: improving mental health and wellbeing, and improving the patient experience. Achieving a financial surplus is now an enabling strategy, to support delivery of the CSP goals.

As this CSP builds on an existing plan, implementation of some initiatives has already begun through the current Operating Plan. Reflection on the challenges of delivery has led to:

- The establishment of the Programme Management Office to strengthen the PCT's programme and project management capacity and capabilities
- An emphasis on performance improvement, which will be reflected in the PCT's values and taken through Organisational Development Plan
- The need for greater, systematic patient and public engagement , which will be driven forward by the Communications and Patient and Public Involvement Strategies.
- The need to work in even closer collaboration with colleagues in the South West London and at the Local Authority which is being taken forward through the 'Strengthening Commissioning' programme as part of the Organisational Development Plan.
- The need for more systematic use of information to drive decision making, which is reflected in the Organisational Development Plan

This CSP then reflects what Croydon people have told us about their needs and aspirations, together with what we know about their health and about the services we commission. It contributes to the Local Strategic Partnership's strategy to make Croydon a better place to live and work and supports delivery of Healthcare for London. It provides a clear strategic framework which will enable us to work with the people of Croydon and we expect it to make a significant and visible improvement to health and inequalities over the next few years.

SECTION 2 – VISION

2.1 The vision for Croydon

Croydon Primary Care Trust is the local leader of the NHS. Its primary aim is: **to enable the people of Croydon to improve their health.** To do this we must ensure:

- Communities and individuals can make informed choices about their health and health care
- Whereby they can maximise their health and well being
- They are supported by high quality services which are responsive to the needs of individuals and which do not unnecessarily disrupt their daily lives
- Where inequalities in health and health services are tackled

This vision is based on the work undertaken by key stakeholders in November 2006. It supports the Healthcare for London vision to make London healthcare services world class by ensuring we add 'life to years and years to life', whilst also ensuring the quality of services are driven up and patients' expectations are met.

The PCT is working as a member of the Local Strategic Partnership to support the development of a 20 to 30 year vision for Croydon and the PCTs vision will be reviewed as part of this work.

2.2 The core values

The PCT has not reviewed its values for some years and the development of organisational values and behaviours is one of the four goals in the Organisational Development Strategy. This will build on the NHS core values:

- **Respect and dignity** - Treating people, whether patients or staff, as individuals - not as symptoms or resources.
- **Commitment to quality of care** - Earning others' trust by insisting on quality and getting the basics right.
- **Compassion** - Finding the time to listen and understand.
- **Improving lives** - Striving to improve health and well-being through excellence and professionalism.
- **Working together for patients** - Putting patients first in everything we do.
- **Everyone counts** – Using our resources for the benefit of the whole community

2.3 The vision for London

The PCT endorsed the Healthcare for London vision for the development of health services in London at the Joint Committee of PCTs in June 2008. Through the Commissioning Strategy Plan and the Collaborative Commissioning Initiatives, the PCT will be taking forward the themes underpinning the vision:

- Reducing health inequalities
- Health improvement and well being
- Regionalisation of relevant services
- Localisation of relevant services
- Personalisation of services
- Development of integration and connected services

The PCTs of South West London share a common vision to maximise the health of our population, increasing life expectancy and improving the quality of that life. In order to do this we intend:

- To build on the existing good health of the majority of our population and improve it.
- To address and reduce the health inequalities where they exist.
- To develop very high quality specialist services in regional or sector centres where quality dictates.
- To increase advice and personalisation of services supported by local provision where possible.
- To increase integration and seamless delivery of services across the care pathway.
- To maximise the deployment of our resources in the delivery of cost-effective services and better value for money

The Commissioning Strategy Plan sets out how we will deliver these visions for Croydon in the context of the future health needs and aspirations of our population as well as other local and national drivers, as set out in section 3. Working in partnership is vital to the delivery of our vision, if we are to tackle the wider determinants of health. The principles by which we will commission services to deliver our vision are provided in appendix 4.

A focus on value for money in the public, private and third sector is essential in achieving the best possible outcomes through the most effective use of our resources. Our residents and stakeholders have an expectation of strong and sound financial management, and expect that our decisions will result in the maximum health gain for the resources that we deploy. .

In Croydon we will actively seek out new ways of working within the Local Strategic Partnership to achieve better value for money and transform services for patients and users, embedding a culture of efficiency within our respective organisations to enable the funding of new and changing service demands and expectations.

Investment and improvement have already begun in many of the PCT's priority areas, as part of the initial Commissioning Strategy Plan and the current Operating Plan. This plan builds on that work.

SECTION 3 – CONTEXT

This section describes the internal and external environment in which the PCT is currently operating. It outlines the PCT's role, the local and national drivers for change, including the changes in Croydon's population, health needs and clinical quality. It identifies insights from key stakeholders including the public, and sets out the PCT's current performance against key national and local priorities. The provider landscape describes the providers of Croydon's health services and is followed by the financial position of the PCT and the activity commissioned. There is an outline of the Primary and Community Service Strategy which underpins the development of future local health service delivery. The key issues arising from this review provide the case for why health and health services must change in Croydon and the strategic context for the outcomes, goals and initiatives in section 4.

3.1 Croydon Primary Care Trust

The PCT's function is to:

- To engage with the local population to improve health and well being.
- To commission a comprehensive and equitable range of high quality responsive and efficient services, within allocated resources.
- To directly provide high quality responsive and efficient services where this gives best value.

Since the PCT was established in 2002, it has maintained financial balance and has developed strong partnerships with a range of partners and stakeholders. The PCT has developed its local knowledge of the population and used this as a basis for its strategic planning. The PCT will need to develop further its commissioning capabilities to become a world class commissioner.

During the process of developing this commissioning strategy plan and the organisational development plan the PCT has identified a number of strengths and areas of significant challenge.

Strengths

- Partnership
- Public health function
- Financial management
- Risk management
- Staff development
- Innovation
- Work with primary care contractors
- Clinical leadership/ engagement

Challenges

- Making our vision real
- Developing explicit values
- Using Public Health expertise
- Systematically linking health needs, goals and initiatives to measurable outcomes
- Focused and systematic use of information
- Managing performance

The PCT will utilize and build on its strengths to support the delivery of the priorities. Our work to address the challenges is reflected in the Organisational Development Plan.

3.2 The local and national context

Locally, Croydon faces significant change in the population, leading to changing needs and demands on the healthcare system. Croydon residents (as demonstrated

through a range of surveys) expect high quality services that are responsive to their needs and aspirations.

Croydon has a strong history of working in partnership and recognises that partners working together can deliver added benefits for everyone living and working in the borough. This approach is reflected in the Croydon Sustainable Community Strategy and the Local Area Agreement. This Commissioning Strategy Plan supports these partnership plans and reflects our understanding of the health needs of Croydon looking forward.

Across South West London the population demographics and needs are diverse but, there are some common themes arising in other PCT Commissioning Strategy Plans. This Commissioning Strategy Plan therefore also supports the South West London Collaborative Commissioning Initiatives which will deliver improvements for renal, neonatal, stroke, trauma, maternity, paediatrics, cancer and mental health services over the next three to five years.

These are areas which need commissioning over a bigger population than that of a single health community to ensure effective commissioning of health services, and where collaboration would lead to strategic impact on the way the service is delivered as well as lead to improved health outcomes for the populations. The Collaborative Commissioning Initiatives are summarised in this document in the description of our initiatives, and the detail is available in the separate Collaborative Commissioning Intentions document.

Nationally, the Next Stage Review and more locally, Healthcare for London set out programmes to improve health and health services over the next 10 years which we will implement in Croydon. These programmes focus on making a real change and delivering what we know patients want – responsive, safe, accessible and high-quality healthcare.

The Next Stage Review focuses on:

- Prevention
- Primary and community care
- Quality
- Information
- Payment system
- Workforce
- Innovation

Healthcare for London's priorities are:

- Greater emphasis on preventing ill-health, by helping Londoners lead healthier lives;
- More specialised care for trauma patients, stroke victims and people needing emergency surgery;
- More specialised care for children, particularly when they are admitted overnight;
- Positive action to address the inequalities across the health system that affect people's access to healthcare and the quality of that care;
- Greater access to GPs and other health and social services closer to home.

In order to deliver our goals and achieve our vision, we will need to develop world class commissioning capacity and capabilities. This is addressed in our Organisational Development Plan and we are working with south west London and other London PCTs to secure scarce skills, share resources, deliver economies of scale and lever greater change. This strengthening commissioning programme is being implemented in a phased approach and the South West London Commissioning Unit will be established along side the pan London Information Hub. Successful implementation of the strengthening commissioning programme is one of the key goals within the Organisational Development Plan. Further background is also provided in appendix 1.

3.3 Population demographics, health needs and clinical quality

3.3.1 Joint Strategic Needs Assessment (JSNA)

The JSNA describes the health and well-being status of the local population, identifies inequities and inequalities, and uses community views and evidence of effective interventions to influence the commissioning of services over the short (3-5 years) and longer term (5-10 years) future.

In Croydon, the JSNA builds on the long history of public health needs analysis and the Annual Public Health reports used widely by the Local Strategic Partnerships and Health Croydon Partnership to inform the Community Strategy and Local Area Agreement, the Commissioning Strategy Plan, as well as individual agencies plans.

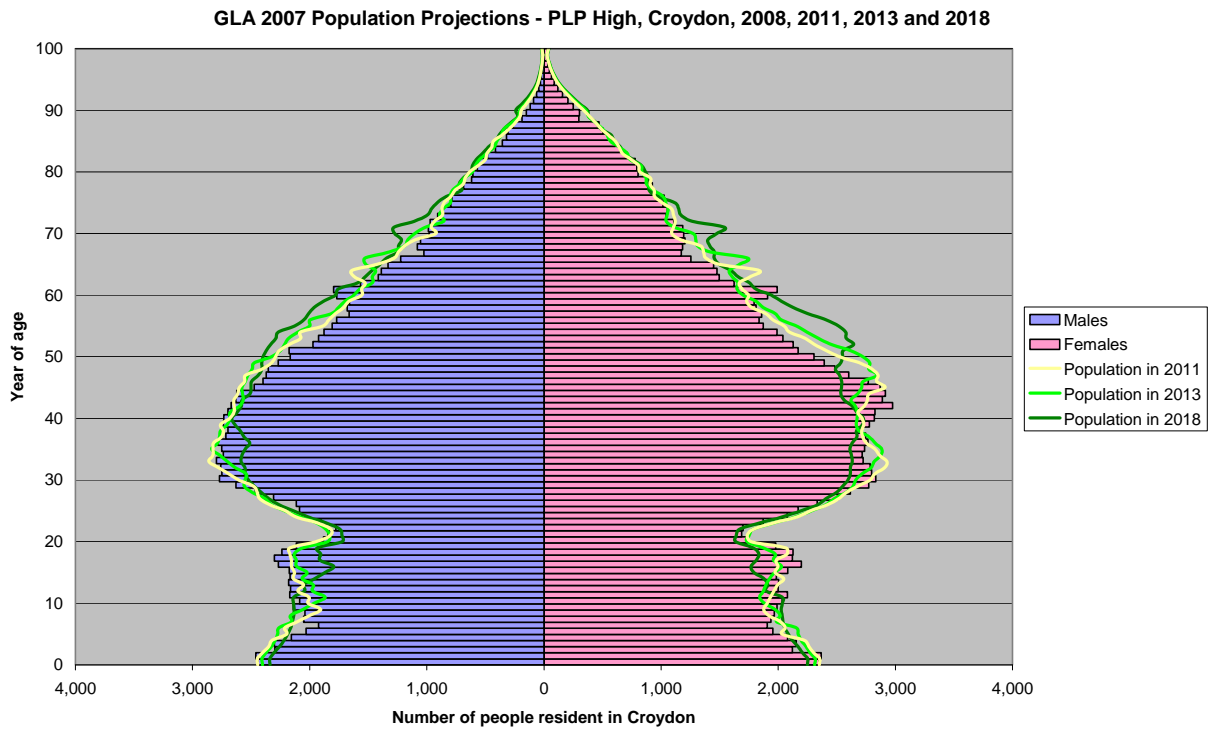
The first JSNA takes the form of a published document, presenting a summary of a core dataset to provide an overview of local health and social care needs, alongside a series of jointly undertaken needs assessments which provide comprehensive analyses for selected priority areas; teenage pregnancy; mental health; and learning disability, physical disability and sensory impairment. From 2009/10 the JSNA core dataset will be updated annually. The JSNA will comprise a rolling programme of needs assessments which will be used to inform local planning. The rolling programme of needs assessments which comprise the JSNA will use a health equity audit approach and will address six aspects of equalities and diversity: age; ethnicity; disability; gender; religion; and sexual orientation.

Chapter 3 of the JSNA, *Future demand for key services*, describes the main changes to Croydon's population that are expected to occur over the short term (3-5years) and the medium term (10-15years) future. The main demographic trends and the health impact of these are summarised in 3.3.2 below. The local health profile, JSNA core dataset main messages and particular areas for concern in relation to disease incidence/prevalence, health outcomes, inequalities and access are considered in section 3.3.3.

3.3.2 Demographic trends

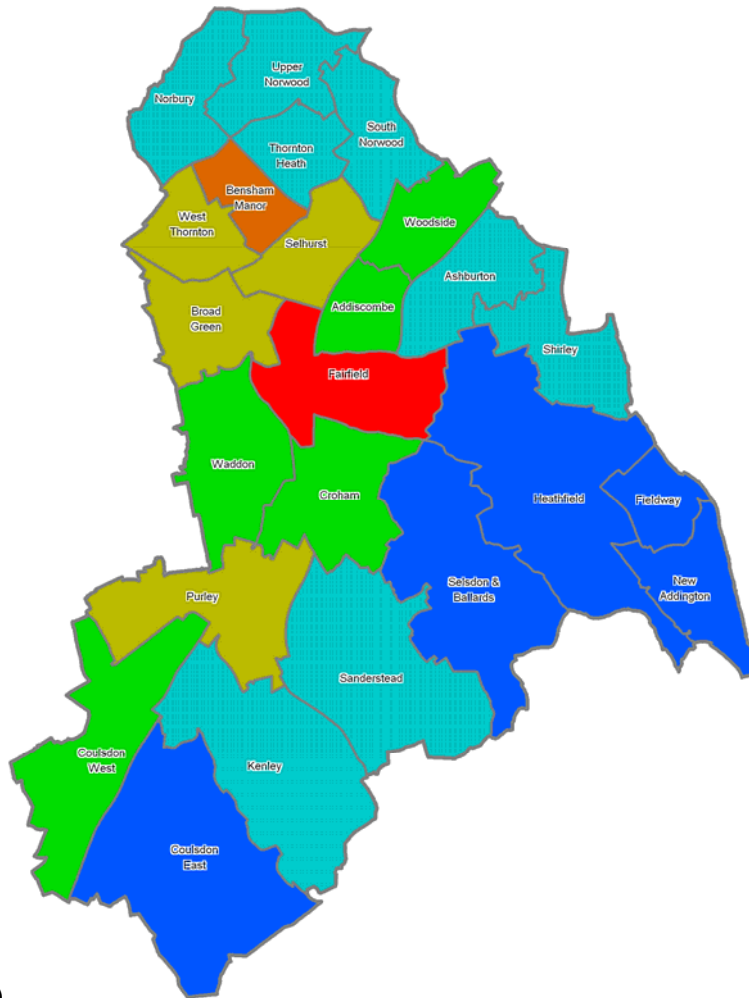
- Population projections

With an estimated resident population of 339,500, Croydon is the largest London borough in terms of population size. The population registered with Croydon GPs is larger still, at 373,000 in April 2008. The population is expected to increase by 1.7% by 2013, which equates to a resident population of 345,300 and a registered population of 379,400.



The rate of population increase will vary across Croydon. Published population projections indicate that the areas of greatest anticipated growth in the next five years are the Fairfield and Bensham Manor electoral wards where the increases are likely to be 26% and 11% respectively. Croydon Council's planning department is able to provide more detailed information with regard to housing developments, which indicates that the greatest areas of growth will be around Croydon town centre. It is anticipated that at least 16,250 additional homes will be built over the next 15 years, with about 10,000 of these in central Croydon. The target is that 50% should be affordable housing, which is likely to impact upon community infrastructure requirements and the demand for, and casemix of, public services

Projected population change, 2008-2013 (GLA constrained population



projections)

Percentage change

- Decrease of more than 2%
- Decrease of 0% - 2%
- Increase of 0% - 2%
- Increase of 2% - 5%
- Increase of 5% - 20%
- Increase of 20% or more

Age structure

Croydon is home to more children than any other London borough. Latest ONS estimates indicate that there are 70,500 children and young people aged less than 16 years living in Croydon. This represents 21% of the total population, which is above the London and England averages of 19%. While the number of children in Croydon is expected to decline slightly over the next five years (to 67,800 in 2013), they will continue to constitute a substantial proportion (20%) of the total population. As is typical of London, a smaller proportion of the population is aged over 65 (13% compared with 12% for London and 16% for England). The number of older people is however expected to increase over the next five years, from 42,300 to 45,100.

Ethnic diversity

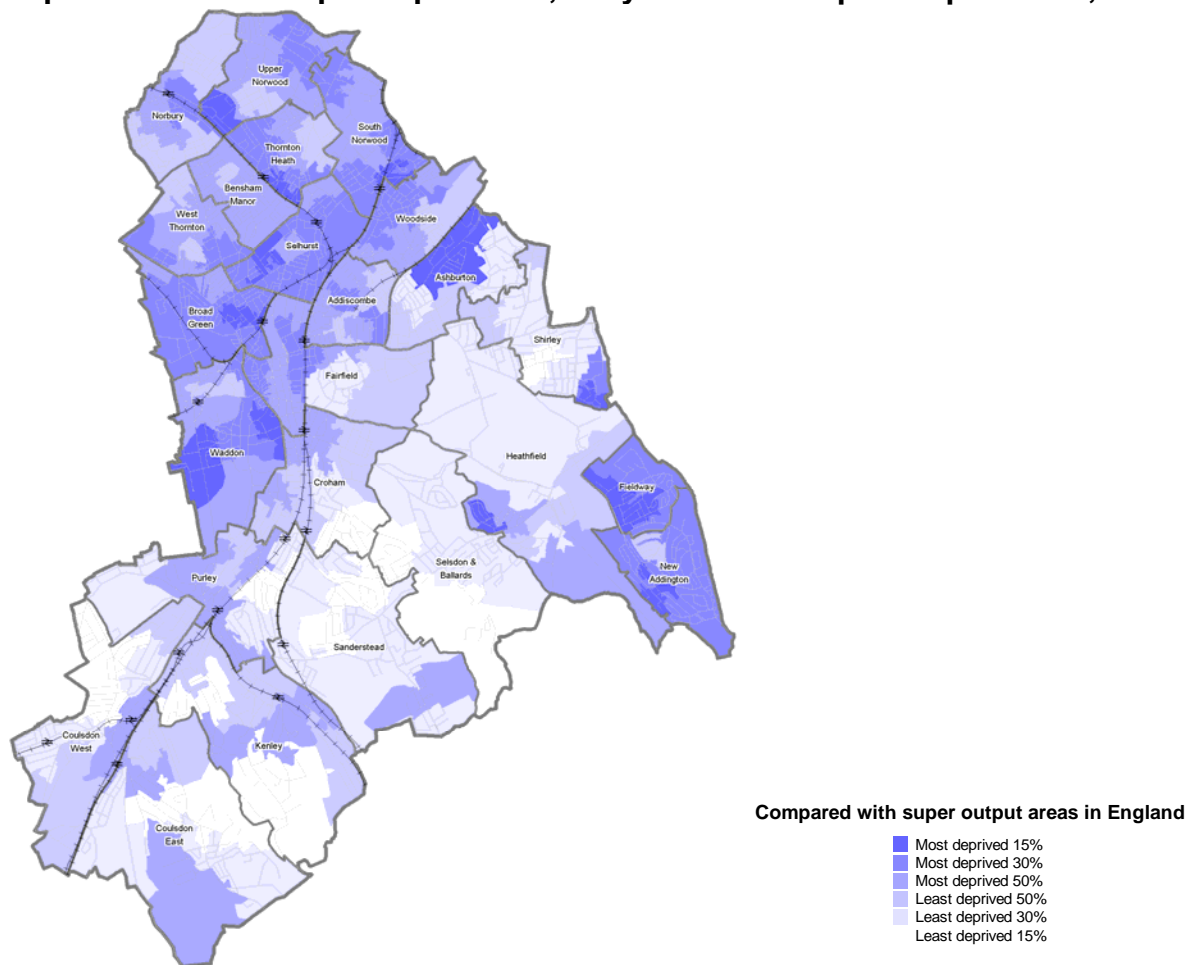
Croydon's population has become increasingly ethnically diverse, with 41% of the population being from Black and Minority Ethnic (BME) groups. Two thirds of the

BME population is aged under 40 and more than half live in the eight northernmost electoral wards in Croydon. The growth in ethnic diversity is expected to continue, with a projected increase to 42% in 2011, 43% in 2013 and 47% by 2018. These projections are likely to be an underestimate as the GLA projections do not distinguish between the White British and White Other population and thus fail to include the large numbers of recent arrivals from eastern Europe within the BME population. The largest increases over the next five years are expected in the Other (+19%), Pakistani (+17%), Black African (+15%), Bangladeshi (+15%), Black Other (+18%), Black Caribbean (+12%) and Indian (+11%) groups. Although age-specific population projections by ethnic group are not available, it can be assumed that the proportions of the population from BME groups will increase across all age groups, leading to important increases in the numbers of BME elders and BME maternities.

▪ Socioeconomic status

The pattern of disadvantage in Croydon is complex, with areas of relative affluence alongside areas of disadvantage. According to the Index of Multiple Deprivation 2007, Croydon is ranked the 125th most deprived local authority of the 354 in England, or 20th of the 33 in London. While two electoral wards in Croydon are among the 10% least deprived in London, two are among the 30% most deprived, and the six most deprived Census super output areas (SOAs) in South West London are situated in Croydon .

Map of Index of Multiple Deprivation, Croydon lower super output areas, 2007



Department of Communities and Local Government, Indices of Deprivation 2007

Data from the last national census show that 42% of Croydon's population under pensionable age work in managerial and professional occupations and 23% work in routine and manual roles. These figures are identical to those for London, with more people in managerial and professional roles and less in routine and manual jobs than is the case for England. At 4%, the proportion of 'never worked or long-term unemployed' is above the national average of 3% but below the London figure of 6%.

The relationship between ethnicity and deprivation or socio-economic status is not clear-cut. Although people from BME groups are more likely to live in the north of Croydon, much of which is comparatively deprived, some of the most deprived areas in Croydon have very small BME populations. More than one third (34%) of the Asian population is employed in managerial and professional roles compared with less than one quarter (22%) of the Black population. Given that the greatest expected population increases are expected among Black groups, if employment patterns remain the same then the proportion of the population employed in routine and manual occupations would rise over the next five years.

- **Health impacts of projected demographic change**

The demographic projections indicate that the population will become older and more ethnically diverse. Increasing age and certain ethnic backgrounds are major risk factors for a number of key diseases, particularly cardiovascular disease. Advances continue to be made with regard to the effectiveness of medical interventions, meaning that people diagnosed with many diseases live longer. Prevalence is therefore expected to increase. It is anticipated that in Croydon, by 2013, there will be 4,700 more people with hypertension; 3,400 more with diagnosed type II diabetes; 680 more people with chronic obstructive pulmonary disease and 680 more cases of coronary heart disease.

3.3.3 Croydon's local health profile

Croydon has a diverse population, in terms of both its ethnic and socio-economic composition. Areas in the north and east of the borough tend to display needs and characteristics similar to inner London boroughs, while areas in the south share more in common with their Surrey neighbours. The future health needs of the population are a function of three key factors: demographic change; changes in health behaviours and health status; and changes in the likelihood of seeking healthcare for any given condition. However, analysis of local data identifies some potential issues of concern and the 2008 local health profile for Croydon prepared by the Association of Public Health Observatories and Department of Health shows a number of comparative indicators of people's health. The table below shows Croydon PCT is significantly worse than average for childhood obesity and physical inactivity, teenage pregnancy, under-15s not in good health, diabetes prevalence and tuberculosis incidence and significantly better than average for a number of smoking in pregnancy, breastfeeding initiation, children's tooth decay, binge drinking adults, hospital stays related to alcohol, physically active adults, male life expectancy, road injuries and deaths, mental ill health, and hip fracture in older people.

Health summary for Croydon

The chart below shows how people's health in this local authority compares to the rest of England. The local result for each indicator is shown as a circle, against the range of results for England which is shown as a bar. A green circle may still indicate an important public health problem.

- Significantly worse than England average
- Not significantly different from England average
- Significantly better than England average
- No significance can be calculated

* relates to National Indicator 2007



Domain	Indicator	Local No. Per Year	Local Value	Eng Avg	Eng Worst	England Range	Eng Best
Our communities	1 Deprivation	50039	14.9	19.9	89.2	[Bar with red circle]	0.0
	2 Children in poverty *	19951	28.3	22.4	66.5	[Bar with red circle]	6.0
	3 Statutory homelessness	581	4.0	4.4	14.4	[Bar with red circle]	0.0
	4 GCSE achievement (5 A*-C) *	2234	58.8	60.1	35.8	[Bar with yellow circle]	82.7
	5 Violent crime	6741	19.7	19.3	38.9	[Bar with yellow circle]	4.5
	6 Carbon emissions *	1888	5.7	7.8	20.6	[Bar with white circle]	4.6
Children's and young people's health	7 Smoking in pregnancy	456	9.7	16.1	38.8	[Bar with green circle]	4.4
	8 Breast feeding initiation *	3971	83.7	69.2	33.2	[Bar with green circle]	90.9
	9 Physically active children *	33685	82.2	85.7	63.3	[Bar with red circle]	99.2
	10 Obese children *	369	12.0	9.9	16.1	[Bar with red circle]	4.9
	11 Children's tooth decay (at age 5)	n/a	1.3	1.5	3.2	[Bar with yellow circle]	0.4
	12 Teenage pregnancy (under 18) *	371	56.3	41.1	83.1	[Bar with red circle]	12.5
Adults' health and lifestyle	13 Adults who smoke *	n/a	23.2	24.1	40.9	[Bar with yellow circle]	13.7
	14 Binge drinking adults	n/a	11.0	18.0	28.9	[Bar with yellow circle]	9.7
	15 Healthy eating adults	n/a	27.8	26.3	14.2	[Bar with yellow circle]	45.8
	16 Physically active adults	n/a	11.3	11.6	7.5	[Bar with yellow circle]	17.2
	17 Obese adults	n/a	19.3	23.6	31.2	[Bar with green circle]	11.9
Disease and poor health	18 Under-15s 'not in good health'	866	12.9	11.6	20.8	[Bar with red circle]	6.4
	19 Incapacity benefits for mental illness *	5240	24.2	27.5	68.6	[Bar with green circle]	8.4
	20 Hospital stays related to alcohol *	744	217.3	260.3	741.1	[Bar with green circle]	87.6
	21 Drug misuse	3096	13.4	9.9	34.9	[Bar with yellow circle]	1.3
	22 People diagnosed with diabetes	14111	4.1	3.7	5.9	[Bar with red circle]	2.1
	23 Sexually transmitted infections						
	24 New cases of tuberculosis	112	33.0	15.0	102.0	[Bar with red circle]	0.0
	25 Hip fracture in over-65s	235	416.6	479.8	699.8	[Bar with green circle]	219.0
Life expectancy and causes of death	26 Life expectancy - male *	n/a	77.8	77.3	73.0	[Bar with green circle]	83.1
	27 Life expectancy - female *	n/a	81.2	81.6	78.3	[Bar with yellow circle]	87.2
	28 Infant deaths	29	6.0	5.0	10.3	[Bar with yellow circle]	0.0
	29 Deaths from smoking	443	216.9	225.4	355.0	[Bar with yellow circle]	139.4
	30 Early deaths: heart disease & stroke *	262	84.5	84.2	142.4	[Bar with yellow circle]	39.7
	31 Early deaths: cancer *	352	115.7	117.1	167.8	[Bar with yellow circle]	76.7
	32 Road injuries and deaths *	154	46.0	56.3	194.6	[Bar with green circle]	20.8

Note (numbers in bold refer to the above indicators)

1 % of people in this area living in 20% most deprived areas of England 2005 2 % of children living in families receiving means-tested benefits 2005 3 Crude rate per 1,000 households 2005-2006 4 % at Key Stage 4 2006-2007 5 Recorded violence against the person crimes (crude rate per 1,000 population) 2006-2007 6 Total end user CO2 emissions per capita (tonnes CO2 per resident) 2005 7 % of mothers smoking in pregnancy where status is known 2006-2007 8 % of mothers initiating breast feeding where status known 2006-2007 9 % 5-16 year olds who spend at least 2 hrs/wk on high quality PE and school sport 2006-2007 10 % Schoolchildren in Reception year. 2006-2007 11 Average (mean) number of teeth per child which were actively decayed, filled, or had been extracted (age 5) 2005-2006 12 Under-18 conception rate per 1,000 females (crude rate) 2004-2006 (provisional) 13 %. Modelled estimate from Health Survey for England. 2003-2005 14 %. Modelled estimate from Health Survey for England. 2003-2005 15 %. Modelled estimate from Health Survey for England. 2003-2005 16 % aged 16+ 2005/06 17 %. Modelled estimate from Health Survey for England. 2003-2005 18 % who self assessed general health as 'not good' (directly age standardised) 2001 19 Crude rate per 1,000 working age population. 2006 20 Directly age and sex standardised rate per 100,000 pop. 2006-2007 21 Crude rate per 1000 population aged 15-64. No significance calculated for lower tier authorities. 2004-2005 22 % of people on GP registers with a recorded diagnosis of diabetes. 2005-2006 23 Indicator blank as data not yet available for local authorities. 24 Per 100,000 population (3-year average crude rate) 2004-2006 25 Directly age-standardised rate for emergency admission 2006/07 26 At birth, years 2004-2006 27 At birth, years 2004-2006 28 Rate /1,000 live births 2004-06 29 Per 100,000 population age 35+, directly age standardised rate. 2004-2006 30 Directly age standardised rate/100,000 pop. under 75 2004-2006 31 Directly age standardised rate/100,000 pop. under 75 2004-2006 32 Per 100,000 population (3-year average crude rate) 2004-2006

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In addition as part of the JSNA, Croydon used the indicative list of indicators published by the Association of Public Health Observatories to prepare a core dataset, obtaining Croydon, London and England values for each indicator in order to identify areas of particular concern. Those areas where Croydon's performance is worse than both the London and England averages are identified as high priorities for action and include:

- Life-expectancy
- Mortality from causes amenable to healthcare (including long term conditions)
- Smoking cessation
- COPD prevalence and mortality
- Flu vaccination
- Incidence of selected cancers (oesophageal, cervical, prostate, bladder)
- Childhood obesity
- Participation in sport and active recreation
- Teenage conception rates
- Chlamydia screening
- Infant mortality

The PCT also analysed health outcome against expenditure according to programme budgeting categories and reviewed other benchmarking activity including the World Class Commissioning data set. This identified further priority areas including:

- Low birth weight
- Immunisation - MMR
- Mental health
- Learning disabilities
- Patient experience

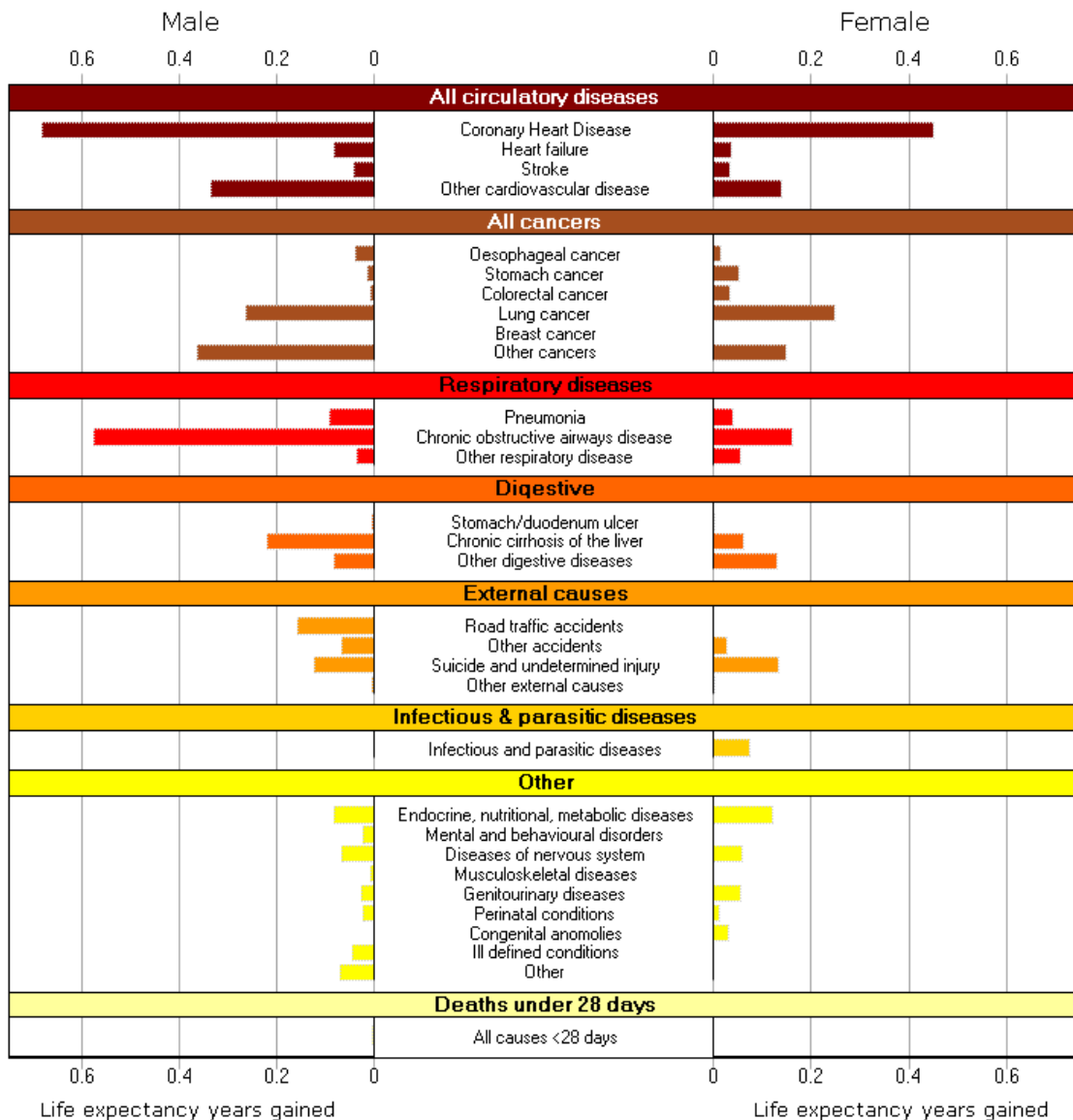
The population health issues for Croydon are discussed in more detail below. These core data set main messages and potential areas of concern were considered as part of the review and prioritisation process in selecting Croydon PCT's 10 priority outcomes which is described in Section 4.

Life expectancy

Men in the affluent areas in the south of Croydon live up to eleven years longer than those in the most deprived parts of the north. There is a similar difference in life expectancy among women, with an eight year difference between the electoral wards with the highest and lowest life expectancy.

The London Health Observatory has developed a tool to quantify the numbers of years in life expectancy that would be gained if the mortality rates in the most deprived areas of Croydon were equal to the Croydon average. The greatest potential health gains are in COPD and CHD mortality.

Life expectancy years gained if the most deprived parts of Croydon had the same mortality rate as the Croydon average for each cause of death



Mortality from causes amenable to healthcare: long-term conditions

Long term conditions place considerable demands on Croydon’s health services. There are currently an estimated 2,900 patients with diagnosed COPD, 8,900 with diagnosed CHD, and 15,000 with diagnosed diabetes. Almost one in four of the population aged 65+ has more than one chronic condition. The prevalence of long term conditions will increase in line with the projected increases in the numbers of older people and numbers of people from ethnic groups with above average levels of diabetes and hypertension risk due to projected changes in the ethnic mix of the local population. Increasing levels of obesity among the population will also contribute to increased prevalence of long term conditions.

Recent modelling undertaken on behalf of NHS London – which takes into account changes in the age, sex, ethnicity, and deprivation profile of the population, and also adjusts for increasing rates of obesity – indicates that the prevalence of type II diabetes (including undiagnosed diabetes) will rise from 5.2% (17,900) in 2008 (4.5%

among men and 5.9% among women) to 6.1% (21,300) in 2013 (5.3% among men and 6.9% among women). The prevalence of hypertension, which is also higher among certain ethnic groups, is expected to rise from 28% in 2007 to 29% in 2013. This increase of one percentage point equates to a further 4,700 people with hypertension and therefore at risk of morbidity and mortality from circulatory disease, particularly stroke. Prevalence rates of other long term conditions – including coronary heart disease (from 4.1% to 4.3%) are also expected to rise during the five years from 2008 to 2013, albeit to a lesser extent.

Circulatory disease is Croydon's biggest killer. Nationally, approximately 15% of the population is considered to be at significant risk of cardiovascular disease (defined as a 20% or greater risk of suffering a cardiac episode in the next ten years). This equates to 30,668 people in Croydon.

The increasing prevalence of long term conditions will have a significant impact on the need for primary health care services. If current trends continue, the annual number of GP consultations in Croydon will rise from 1.1 million in 2008 to 1.2 million in 2013, and the annual number of total primary care consultations will rise from 1.8 million in 2008 to 2.1 million in 2013.

Data from general practice systems shows prevalence increases for a range of conditions. For many conditions, the GP recorded prevalence figures are lower than would be expected on the basis of population composition. This suggests there may be under-diagnosis or under-recording.

Trends in numbers of people with conditions recorded as part of QOF disease registers, 2005-2008

	March 2005	March 2006	March 2007	March 2008
Atrial fibrillation			3,203	3,127
Asthma	17,735	17,781	18,108	18,083
Hypertension	37,848	39,445	41,213	42,971
Cancer	1,438	2,139	2,742	3,283
CHD	8,812	8,707	8,771	8,880
CKD			6,425	7,172
COPD	2,418	2,545	2,716	2,902
Dementia			1,206	1,269
Diabetes	13,052	13,915	14,238	15,017
Epilepsy	1,688	1,788	1,779	1,774
Heart failure			1,981	1,945
Learning disability			880	930
Mental health			3,431	3,537
Obesity			25,116	26,806
Palliative care			186	257
Stroke or TIA	3,593	3,887	4,049	4,162
Hypothyroidism	8,571	9,814	10,678	11,311
Total list size	359,874	363,708	367,485	370,197

Data from general practice also indicate that there is potential for improvement in the management of long term conditions. For example, as at March 2008, the proportion of diabetics with well controlled blood sugar (HbA1c <7.5) was notably below average, at 54%, compared with 60% nationally.

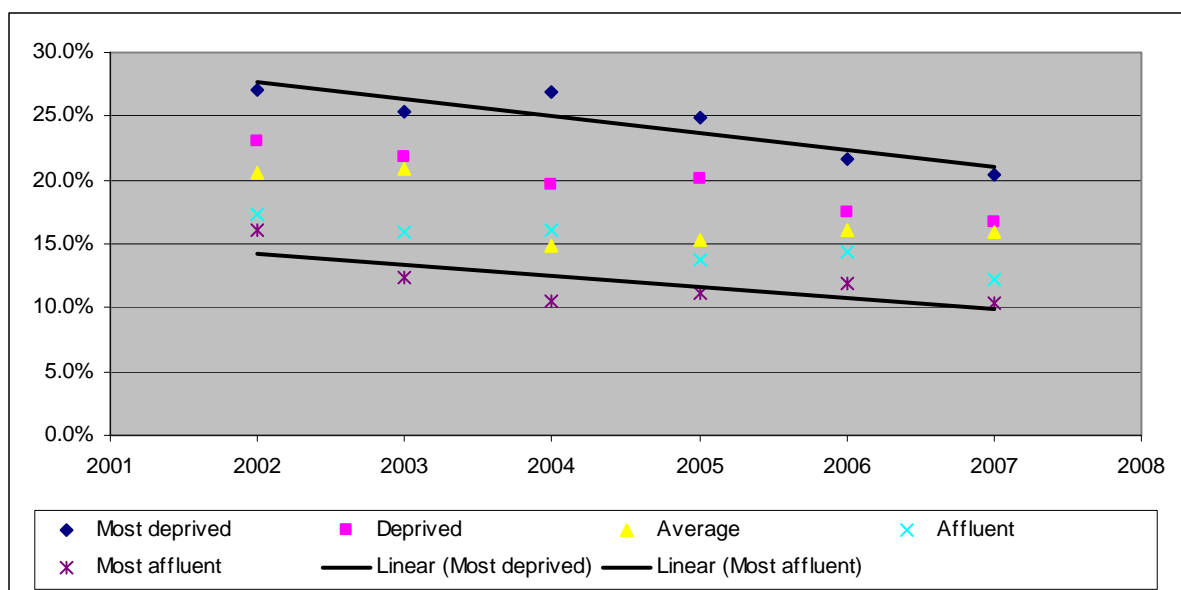
Smoking cessation

At an estimated 23%, smoking prevalence in Croydon is below average, although not significantly so. There are substantial variations in prevalence rates across the population. Prevalence is highest among men aged 25-34 (34%) and among the White British (30%) and White Irish (36%) ethnic groups. It is notably more common in deprived areas of the borough, particularly Fieldway & New Addington, where prevalence is 34%. Analysis of local data (obtained by surveying ten percent of the population annually) reveals that inequalities between the most and least deprived areas of Croydon have reduced for a number of lifestyle indicators, and particularly the prevalence of heavy smoking. Smoking remains more prevalent in areas with higher levels of socio-economic deprivation, but the gap is decreasing as prevalence is falling at a faster rate than it is in the least deprived areas.

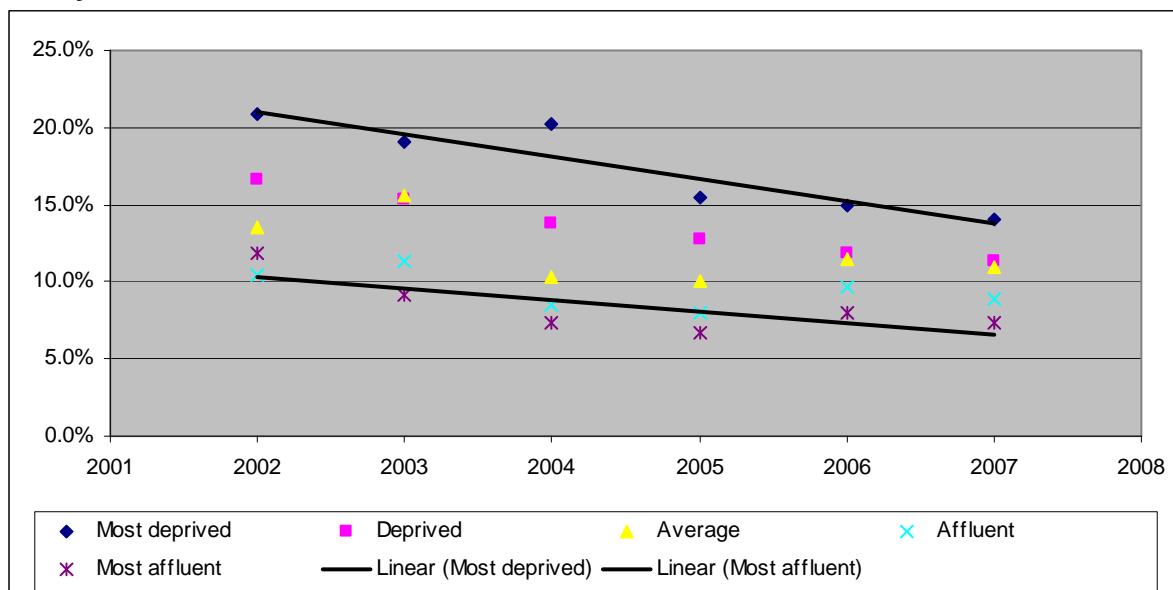
Smoking is the single largest cause of preventable illness and premature death in the UK, and contributes more than any other identifiable risk factor to inequalities in healthy life expectancy. Reducing the prevalence of smoking will have a considerable positive impact on a range of health outcome indicators, particularly mortality from the three biggest killers in Croydon: circulatory disease (32%), cancer (25%) and respiratory disease (15%) and addressing this is a priority not only for the PCT but also for partners as part of the Local Area Agreement.

Trends in smoking behaviours: differences between Croydon's most and least deprived groups, 2002-2007

Current smoker



Heavy smoker



Chronic Obstructive Pulmonary Disease (COPD) prevalence and mortality

In Croydon, the age-standardised mortality rate for COPD during 2004-06 was notably above average, at 30.6 deaths per 100,000 compared with an England average of 27.0. Prevalence of COPD, modelled on the basis of population composition, is an estimated 4.5%, but GP recorded prevalence is 0.7%, suggestive of under-diagnosis or under-recording in primary care. Investment in respiratory conditions in Croydon is above the England average but below average for similar PCTs. The prevalence of chronic obstructive pulmonary disease is expected to rise from 4.5% to 4.6% during the five years from 2008 to 2013. These combination of factors make it an important health issue for Croydon.

Tackling smoking will also have a significant impact on reducing mortality from respiratory disease.

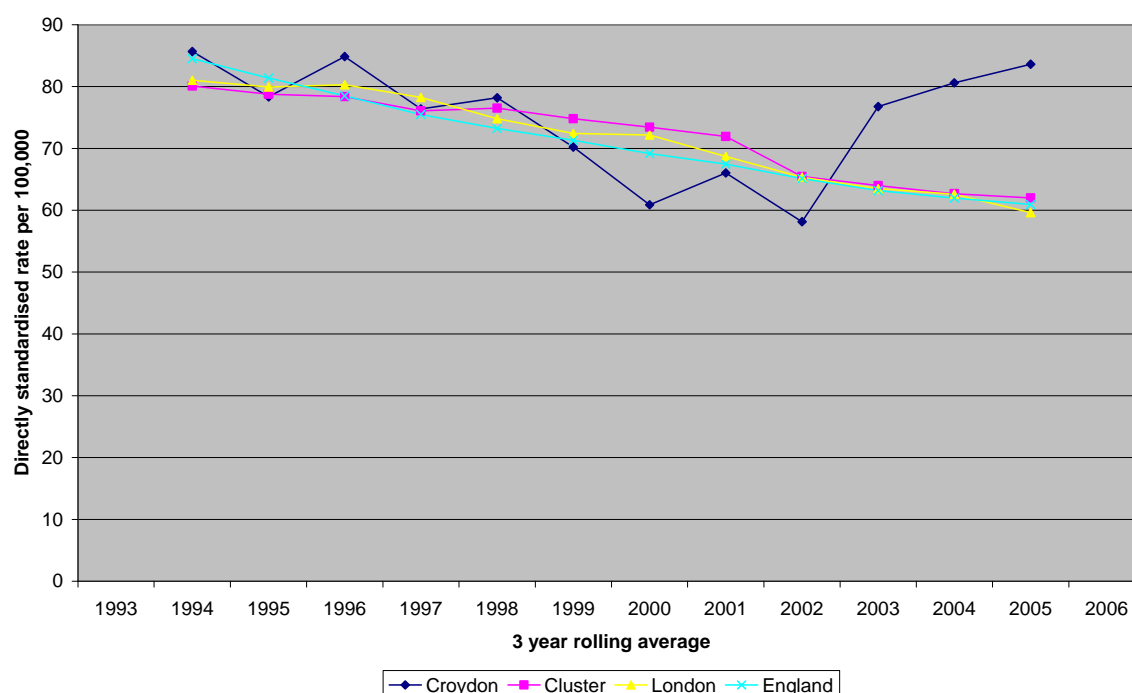
Flu vaccination

In 2006/07, flu vaccination uptake was 69% in Croydon, compared with 70% for London and 74% for England. Increasing the uptake of flu vaccination will reduce mortality from COPD and related conditions and will decrease the numbers of excess winter deaths and admissions to hospital.

Cancer incidence

The top two health programmes (in terms of expenditure) at Croydon's hospital providers are mental health and cancers. The cancers programme is divided into ten subcategories. Croydon's expenditure is lower than average for lung cancer and lower gastrointestinal cancer. Lung cancer mortality in Croydon is also significantly lower than average. Croydon has the highest breast cancer mortality rate among 50-69 year olds in England. The rate has been significantly above average and increasing for the past five years. The latest published data suggest a breast screening coverage rate of 67%, below the national 76% but above the 64% London average.

Trend in breast cancer mortality at ages 50-69, 1993-2006



Standardised mortality ratios for cancers, all ages, Croydon, 2004-2006

Cancer (ICD-10 codes)	Croydon		Cluster	London
	Number	SMR	SMR	SMR
Oesophageal cancer (C15)	87	88	81	79
Stomach cancer (C16)	84	113	98	99
Colorectal cancer (C17-C21)	206	93	93	93
Lung cancer (C33-C34)	386	87	90	101
Malignant melanoma (C43)	25	95	84	87
Other skin cancers (C44)	6	85	97	94
Breast cancer (C50)	203	117	103	99
Cervical cancer (C53)	17	114	85	96
Prostrate cancer (C61)	163	113	100	96
Bladder cancer (C67)	49	74	90	93
Leukaemia (C91-C95)	65	107	105	101
All cancers (C00-C97)	2,032	97	95	97

Source: *Compendium of Clinical and Health Indicators, NCHOD*

Cancer mortality rates are also above average for stomach cancer, cervical cancer, prostate cancer and leukaemia. Tackling smoking and obesity will have a significant impact on reducing cancer mortality rates.

Childhood obesity

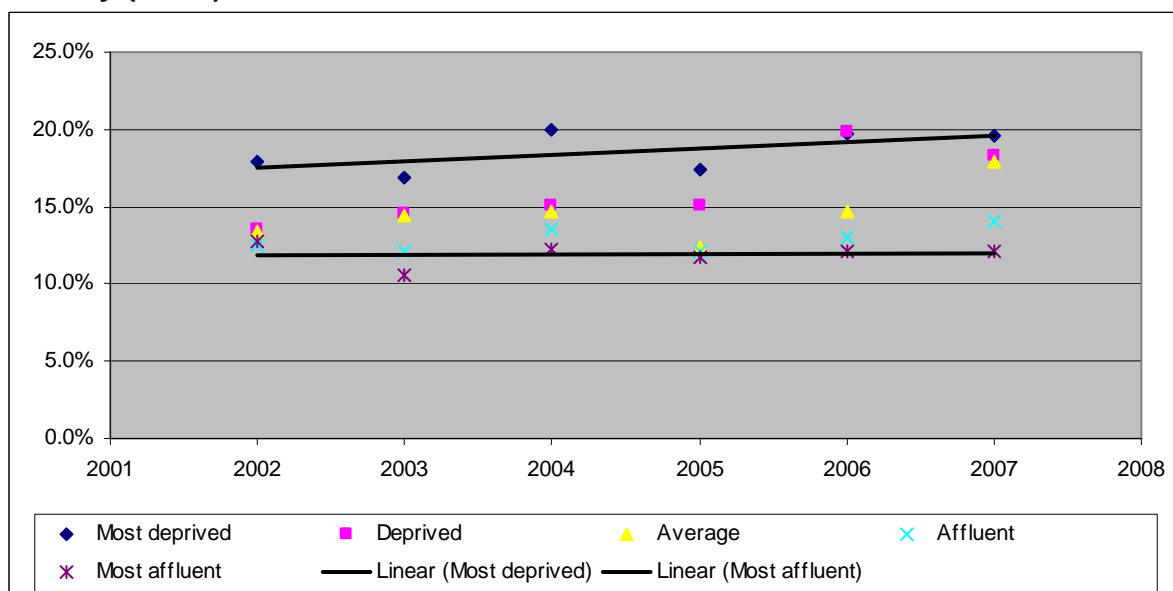
Tackling obesity is a key local and national priority. If current trends continue, then one third of all adults, one third of all girls and one fifth of all boys will be obese by 2010, with major health impacts across a range of conditions. National estimates suggest that Croydon has a higher proportion of adults who eat healthily and a lower proportion of obese adults than the national average. However, local data show that obesity rates vary substantially across the PCT and appear to be closely linked to deprivation levels. Local data indicate childhood obesity rates are above the national average in both of the school years (reception year and year 6) included in the National Child Measurement Programme. Breastfeeding contributes to reduced levels of childhood obesity and while the PCT is meeting its breastfeeding initiation targets, local data indicate considerable inequalities within the population which must be addressed. Tackling childhood obesity is one also of the Local Area Agreement priorities.

The extent to which people in Croydon are engaged in taking responsibility for their own health will have a major impact on future health needs, and encouraging and enabling people to adopt healthy weights and healthy lives is key to reducing the risk of developing a range of long term conditions and improving both physical and mental health and well-being.

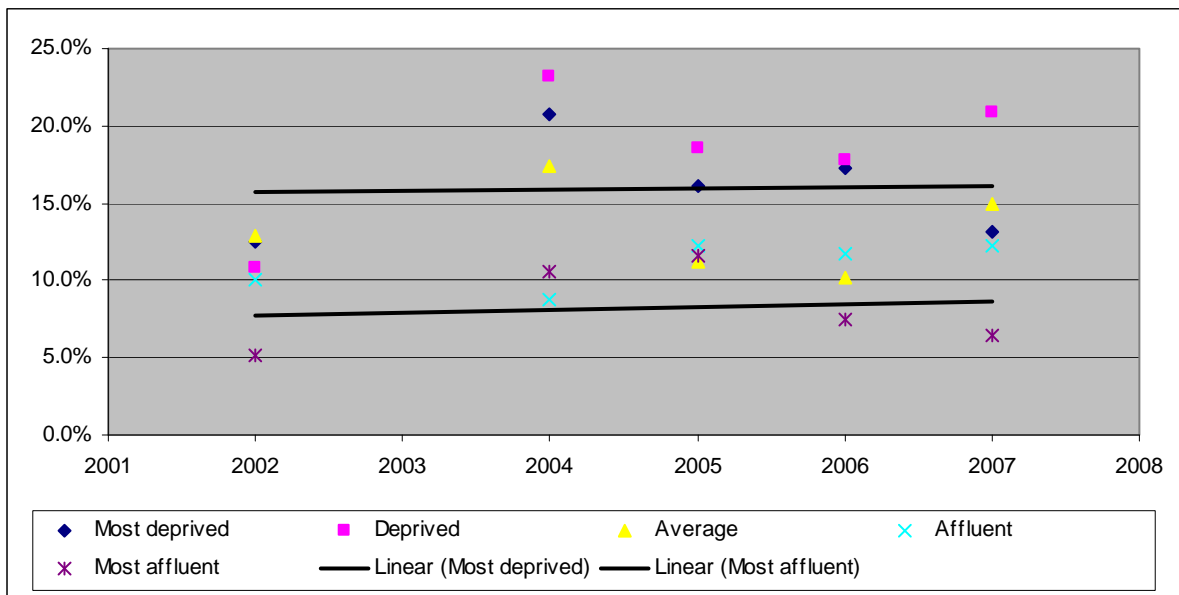
Local trend data is indicative of inequalities in obesity rates according to deprivation level, and illustrates that among adults, the gap between the most and least socio-economically deprived parts of Croydon is increasing.

Trends in obesity: differences between Croydon's most and least deprived groups, 2002-2007

Obesity (adult)



Obesity (child)

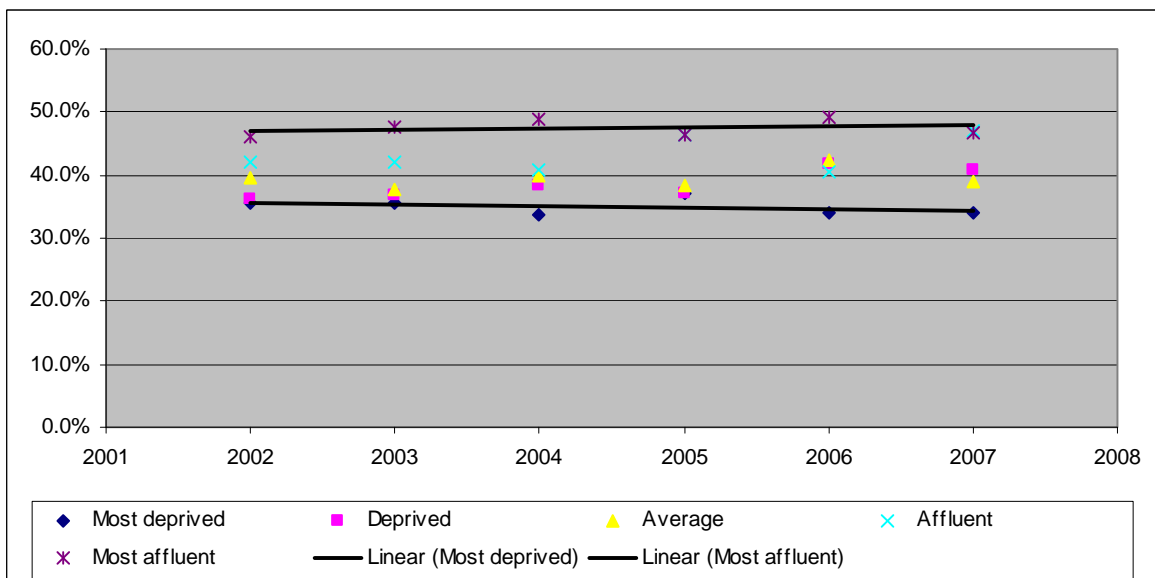


Participation in sport and active recreation

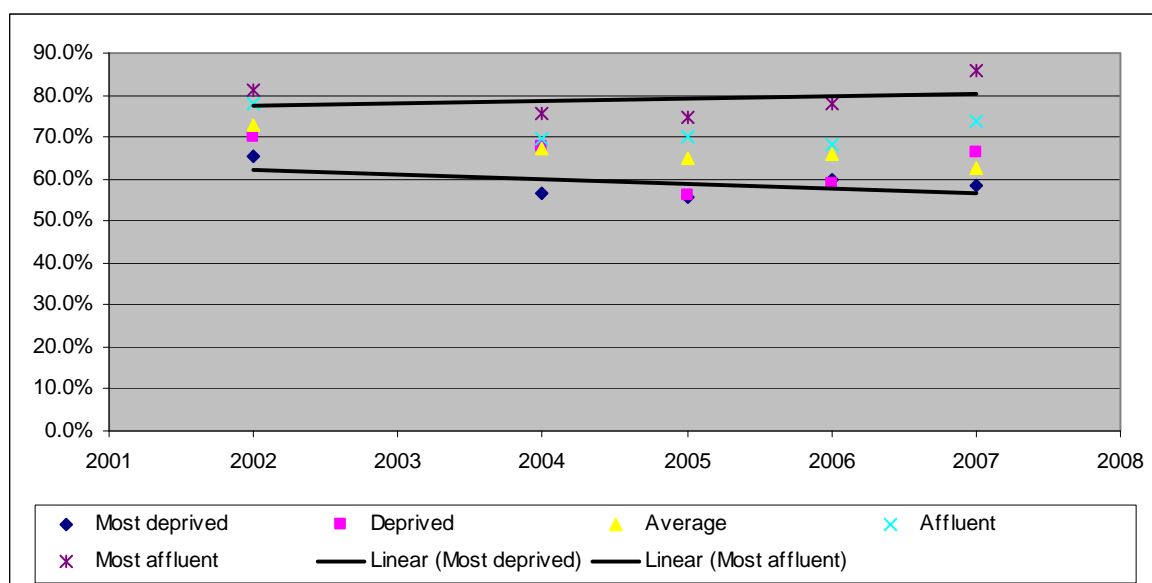
Physical activity has important physical and mental health benefits, including protection against and assistance in tackling obesity, and reduction of the risk or severity of mental health problems such as depression. Local survey data illustrates trends in the population inequalities in participation in regular physical activity.

Trends in participation rates: differences between Croydon's most and least deprived groups, 2002-2007

Regular physical activity (adult)



Regular physical activity (child)



Teenage conception rates

Tackling teenage pregnancy is crucial to improving the health and well-being of the population. Research evidence consistently shows that teenage parents and their children have poorer outcomes, including higher rates of infant mortality and postnatal depression, than those delaying parenthood, even after socio-economic factors have been taken into account.

Croydon has a high teenage conception rate and, although this has declined over recent years, the rate of decrease is insufficient to meet the 2010 target. Every year, about 370 girls aged under 18 become pregnant. In 2006, this equated to a rate of 56.9 conceptions per 1,000 girls aged 15-17, which was notably higher than the rates for London and England, at 45.6 and 40.6 respectively and the provisional 4 quarters conception rate data from April 2006 to March 2007 show an increase in the Croydon rate to 60.0 per 1000. Teenage pregnancies are influenced by a broad range of social determinants and addressing this is an important partnership priority within the Local Area Agreement.

Croydon is home to more children and young people and has more schools than any other London borough. It has seen an unprecedented rise in the number of looked after children and young people. There are notable challenges in many of the health outcome targets which focus on children and young people, and there are high levels of unmet need among looked after children and young people, whom research demonstrates are over-represented among teenage parents, drug users, youth offenders and prisoners.

Chlamydia screening

There are high, and increasing, numbers of diagnoses of sexually transmitted infections: in 2006, 895 new cases of Chlamydia were diagnosed at Mayday GUM clinic, an increase of 92% on the 465 cases in 2002. Croydon is also not currently meeting the targets for the Chlamydia screening programme, which is focused in particular on young people aged 15-24.

Infant mortality, Low Birth Weight and Maternity

Over the past five years, the numbers of live births to Croydon mothers has risen from 4,600 to 5,300. The latest available data indicate a rise in perinatal and infant mortality rates, which were significantly above the national average in 2006; the infant mortality rate was 6 deaths per 1,000 live births (compared with 5 for England) and the perinatal mortality rate was 10.5 stillbirths and deaths in the first week of life per 1,000 total births (compared with 8.0 for England). Local epidemiological analysis suggests that this is as a result of changes in the population composition, with particularly high rates in women from Black ethnic groups. Low birth weight is a major risk factor for infant and perinatal death, and research has shown that low birth weight babies experience poorer health outcomes throughout their lives. During 2001-2005, more than 70% of babies and infants who died were of low birth weight, compared with just 10% of babies who survived.

The successful implementation of Maternity Matters will require decreases in the numbers of caesarean sections and invasive interventions and an increase in the numbers of home births. Local audit data show that in 2006, 23% of births at Mayday hospital were delivered by caesarean section, and that 37% of these were planned caesareans. Currently, just 2% of births to Croydon mothers are home births.

Research has shown that children with poorer birth outcomes experience poorer health throughout their lives. In addition to the simple fact that children have more years of life remaining in which their health can be improved, targeting health promotion initiatives at mothers and children will also help to break generational cycles of poor health.

Immunisation

Immunisation saves lives, protecting against serious diseases, such as measles, meningitis C and polio, which can lead to permanent disability or death. Immunised children are also less likely to be a source of infection to others, meaning that those who cannot be immunised should still benefit through "herd immunity", though this is only effective when almost all children are immunised. When the numbers immunised fall too low, as has been the case in recent years, outbreaks of disease occur, such as the recent rise in cases of mumps and measles in London. Coverage of 95% is required in order to achieve herd immunity. In Croydon, in 2006/07, the proportion of children immunised for mumps, measles and rubella (MMR) by their 2nd birthday was 77% (compared with 75% for London and 85% for England) and the proportion immunised by their 5th birthday was 59% (compared with 52% for London and 73% for England). Immunisation uptake for diphtheria, tetanus, polio, pertussis (whooping cough) and haemophilus influenza type b (DTaP/IPV/Hib) was higher, at 91% at age 2, but remains short of the target for herd immunity.

Mental health

Expenditure on mental health is slightly below the average for similar PCTs but above the England average. The majority of expenditure was in the 'other mental health' category. The suicide mortality rate is close to the England average. Acute inpatient admissions for mental health problems have increased over the past three years. The most significant increases in acute admissions locally have been for

common mental disorders, which could be diagnosed and treated within primary care. The rate of common mental health problems (depression and anxiety disorders) in Croydon is estimated to be 172 per 1,000 population, which is similar to the national average. There is some variation in prevalence by age group, deprivation and sex. Nationally, less than a quarter of people with anxiety disorders, and a third of people with depression, are receiving treatment. The most effective treatments for depression and anxiety disorders are psychotherapy (particularly time-limited cognitive behavioural therapy), and medication such as selective serotonin reuptake inhibitors (a type of anti-depressant). Evidence suggests that 50% of people with depression or anxiety will require treatment with psychotherapy and/or medication.

Learning disabilities

About 2% of the population has a learning disability, based on the definition in the national strategy "*Valuing People*". Many of these people manage without needing to use specialist health or social services, but they are at risk of unequal access to services and require appropriate forms of communication. An estimated five people in every thousand has a learning disability that requires specialist services and ongoing support. In Croydon, this equates to 5,200 people with a learning disability, of which 1,300 require specialist support. In March 2008, 930 Croydon patients had a learning disability diagnosis recorded in their GP notes. As at 1 April, 1,188 Croydon adults were served by Croydon's Joint Community Learning Disability Team.

Patient experience

In light of the projected changes in the population composition and associated increases in prevalence of particular conditions, there will be significant increases in the demand for health services. There is also a need to ensure that patients use the services most appropriate to their health needs in the most appropriate local setting. However, findings from surveys of patients and recent engagement initiatives show that people in Croydon report poor experiences of accessing and using services.

Although satisfaction with the quality of care received has remained relatively constant since 2004, satisfaction with the accessibility of GP services has fallen significantly and consistently. Overall levels of satisfaction with general practice in the national survey have fallen from a mean score of 76.4 out of 100 in 2004 to 75.6 in 2007.. In the 2008 survey the PCT was in the best performing 20% of PCTs in four out of 25 key questions, but in the bottom 20% of PCTs for 11 questions even where some apparently high satisfaction scores have been recorded. This reflects the higher level of satisfaction recorded nationally and the need for the PCT to make further improvements to meet public expectations. In the most recent GP Patient Experience survey which focuses on access improvement is required in the 3 areas of telephone access, access to specific GP and opening hours in 2008/09. Further improvement is required across all areas over following years.

Data from a local survey of 34,000 Croydon patients similarly indicated that while satisfaction with the quality of care provided in general practice has remained relatively constant, satisfaction with access to this care has fallen; despite improvements made to opening hours and appointment booking facilities.

Patient choice and booking remains a key priority for the Department of Health and is an important indicator for the PCT on patient experience. In 2007/08 the average percentage of referrals booked via the Choose and Book (CAB) application in Croydon was 30% against a national target of 90%. The number of patients surveyed in March 2008 recalling a choice discussion was 46% against the national target of 80% and national average of 47%. Based on poor benchmarked performance the PCT, as part of the Operating Plan 2008/09, submitted recovery trajectories and selected VSC 16 as local vital sign. Also based on a national survey in March 2008 the percentage of patients aware that they have a choice of hospital for their first appointment was 33% and the percentage of patients who went to the hospital they wanted or had no preference was 87%.

The recent Healthcare Commission Maternity Service Review placed Mayday in the category of "least well performing" Trusts. Mayday was also among the 20% worst performing Trusts for patient perceptions about the overall quality of inpatient care received. The Healthcare Commission's 2007 survey of community mental health services revealed that 63% of patients at SLaM rated the overall quality of care received as good to excellent. This is below the national average of 77% (27).

Local data indicate that patients living closer to Mayday hospital are more likely to attend A&E with conditions that can be more appropriately managed in primary care. A London report estimates that 40% of people attending A&E have a problem which can be treated in primary care; this figure is likely to be higher among residents living in close proximity to A&E.

The Croydon End of Life Care (EoLC) review in 2006 found that in general unless receiving hospice care or a referral to the district nursing service, EoLC in Croydon tends to be delivered when patients reach a crisis and require urgent access to services. The review also found that many people do not receive the care they need because referrals are made too late (e.g. 53% of referrals to the Crossroads palliative care respite service did not happen because the patient died before the service began).

3.4 Insights from patients, public, clinicians and local partners

The PCT is committed to ensuring stakeholders, patients and the public have a real say in the commissioning, design and delivery of services, which is being taken forward through the Patient and Public Involvement Strategy. It builds on the existing examples of good practice.

The PCT has good links with intermediary groups, such as the local voluntary sector, patient and community groups and LINKs in order to engage local patients and the public. The multi-agency Croydon Community Involvement Commitments includes the commitment not to duplicate consultation where this has already taken place. The PCT draws on the results of previous consultations, such as the consultation on Choosing Health existing networks and established local involvement processes as well as specific involvement initiatives to develop its plans for the future.

The PCT has strong working relationships with clinicians who are engaged in the development and implementation of CSP goals. PEC clinical champions lead the service redesign programmes, together with Practice Based Commissioning leads.

PBC plans are well established and drive the review and redesign of clinical pathways across secondary and primary care and a range of clinicians engage through regular PEC clinical forums, and through PBC and partnership groups. The PEC also takes an increasingly visible leadership role with the public such as presentations to public forums on Healthcare for London and the PCT's Primary and Community Care Strategy.

There is a good track record of local joint working in Croydon and an extensive structure of cross-agency partnerships. The Local Area Agreement (LAA) incorporates targets where there is joint responsibility between the Council and the PCT. Regular involvement takes place through Croydon's family of partnerships within the Local Strategic Partnership and the 14 specific partnership groups relating to health and health care all of which have representatives elected from and by the voluntary sector.

All engagement and formal consultation activity is included on the Talk2Croydon website, which also provides the opportunity for people to comment even if they do not wish or are not able to access organised involvement activities.

3.4.1 Engagement in strategic planning and service design

The PCT began its strategic planning in the Autumn of 2006, shaping the vision for Croydon with key partners. The process became part of the commissioning strategy plan development in May 2007 and we have continued to engage stakeholders as part of the refresh of this Strategy. For example a stakeholder event was held in September 2008 to consider the Joint Strategic Needs Assessment and to inform the prioritisation of ten outcomes.

The PCT has also undertaken many initiatives to find out what matters to patients, carers and the public. These include surveys (e.g. annual survey of 10% of patients on GP and GDP lists), qualitative research (e.g. focus groups), informal engagement exercises (e.g. workshops, large scale events) and formal consultations. These involvement initiatives have been part of work to help assess the needs and aspirations of communities, plan services, inform priorities, support service improvement and/or monitor the experiences of people who use services. The outcome of these and of national surveys have helped shape the CSP and inform the PCTs overall priorities and initiatives.

The Professional Executive Committee and the Practice Based Commissioning Board has been integral to the development of the CSP and specifically with the initiatives to deliver the goals.

3.4.1 Engagement and Consultation Outcomes

Key messages from recent feedback

▪ Choosing Health

The PCT has engaged with the public and community and voluntary organisations to respond to *Choosing Health* priorities. An initial consultation in 2004 identified a number of key areas that local people told us were important for them. Themes arising from the consultation included family and individual income, work and worklessness, the quality of relationships (both personal and with professionals), and

access to services. These themes have shaped the design of key initiatives. The breastfeeding peer support programme, for example, targets women in an area of high deprivation by making use of peer rather than professional relationship to support initiation and sustaining of breastfeeding.

Following the publication of the White Paper a series of *choosing health days* have brought local communities, the voluntary sector, the PCT, council and local businesses together around priority themes. At the *Choosing Health day* at the family centre in Fieldway & New Addington the focus was on developing family friendly interventions. This influenced the development of work to tackle bullying and also on a 'healthy lunchbox' project. The *choosing health day* at the Waterside healthy living centre helped shape proposals for work with older people including falls prevention and tackling fuel poverty.

A multi-agency stakeholder event "Choosing Health in Croydon: making it happen" (September 2006) brought together representatives from the PCT, local authority and a range of voluntary and community groups. In order to inform the development of implementation plans for the choosing health priority areas (smoking; obesity; sexual health; mental health; and alcohol), participants were invited to share their views on the national priorities and how Croydon agencies and communities could best work together to improve health and reduce inequalities.

- Long term conditions

The whole systems approach to Long term conditions was initiated and developed by senior clinicians reviewing patient experience of health care. Ongoing developments in the Virtual Community Ward and supported self management are informed by clinical feedback on patient needs. e.g. the identification of patients with mental health and substance misuse problems has led to the proposal to improve mental health assessment and training for community matrons.

In Summer of 2008 the PCT undertook a small scale survey of people with a long term condition asking them what helped them keep well. The outcomes of this survey indicated patients valued

- voluntary sector support
- practical help like transport and help with house and garden maintenance
- help with benefits
- Community health staff including pharmacists.

The PCT will continue to test these principles more widely but will as a result of this feedback be

- working with the voluntary sector to develop patient responsive services and information
- working with Local Pharmacy Committee to establish how to maximise the potential of the new pharmacy contract in supporting people with LTC to better manage their own condition.

The PCT will be undertaking a review of Joint Strategic Needs Assessment outcomes in relation to long term conditions in January 2009 with a view to establishing priorities for service and commissioning development. This review will incorporate health profile information provided at a cluster level to facilitate

consideration of local issues and will test proposals for investment with patient and carers groups.

- End of Life Care

The Croydon End of Life Care baseline review in 2008 engaged Council voluntary sector and health care providers to obtain a provisional assessment of development opportunities in Croydon End of Life Care. The PCT has also engaged other methods to seek views of patients and carers about end of life care. This included the Big Question week and during the consultation on Healthcare for London. There was a strong call for a carers resource pack and respite services. Staff were also asked about how to improve the patient experience at the end of life. Key themes were

- The need for a rapid response service
- The need to create time for health staff to understand the wishes of patients and carers.

Service developments for 2009/10 and to 2013 are therefore likely to include:

- Development of a resource pack for carers
- Review of respite services
- Supporting the roll out of Gold Standards Framework (a best practice model for planning care for people at end of life)
- Develop rapid response service to support patients that wish to, to die at home.
- Support for care homes (particularly for elderly mentally ill) to provide end of life care support to patients who wish to remain in their care home.

- Planned care

Practice Based Commissioning (PBC) groups are engaged in reviewing clinical pathways to increase the range of services in primary care and to reduce unnecessary secondary care activity. PBC is a vehicle for effective clinical leadership and engagement.

Multi-agency groups such as the Local Diabetes Service Advisory Group and the Oral Health Advisory Group, as well as other successful joint partnership groups and local representative committees enable primary care to liaise with colleagues in secondary care, social services, voluntary sector and service users.

We have worked in collaboration with the PBC groups, Local Medical Committee (LMC), Local Optical LOC, LPC, individual clinicians, patient groups and with Mayday hospital in the development of these initiatives

GP feedback regarding secondary care access along with service user survey results identified concerns for a number of areas including ENT, Gynaecology and Pulmonary Rehabilitation as: long waiting times, the number of follow ups required before treatment was completed and poor patient experiences of the services as a whole. This prompted the PBC group prioritise the setting up of primary care led services directly accessible to GPs for both ENT and Gynaecology.

- Maternity

Engagement and consultation has been critical to the future development of maternity services and has involved Mayday NHS Trust, PBC group, Local Medical

Committee, Community Health Services, service users and carers and community groups. It includes:

- The maternity quality premium scheme which incorporates a community involvement component across all relevant agencies
- The Maternity Services Liaison Committee has a robust governance structure comprised of a cross section within the local health community, clinicians, service users, National Childbirth Trust, managers and other relevant agencies.
- Healthy Croydon Partnership held a session recently focusing on improving health and wellbeing of women during pregnancy and following childbirth.

The key themes arising from the Healthy Croydon Partnership seminar were:

- that tailored information and peer support were key to ensuring that women get the advice and support they need once they have given birth
- peer led courses for people thinking of having a baby and research with people who did not access maternity services early were key to effectively developing and promoting early access to maternity services
- clearer information and one to one relationships would enable choices and better involve women in their care
- development of information at all stages of the maternity pathway linked to a plan of care would ensure that all women have enough information during pregnancy, during labour and birth and after the birth

▪ Mental Health Day services

Formal consultation on the proposed modernisation of adult mental health day services was conducted at the end of 2007. Some key outcomes of the consultation:

- confirmed the significance of the mental health promotion agenda
- the importance of linking a range of support services such as employment support and debt advice to a developing range of psychological therapy services.
- the importance of social inclusion as a key aspect of mental health recovery and indicating a number of areas of need that would not be fully addressed by the proposed improvements to day services.

▪ Patient experience feedback

As discussed above, recent survey results show that people in Croydon report poor experiences of accessing and using services. Similarly, recent listening events with members of the public as part of our efforts to improve primary and urgent care (described below) reveal inconsistencies in quality of care and particular problems regarding access and communication.

Healthcare for London

The Healthcare for London consultation provided significant response to the proposed reforms across London. The responses provided by Croydon residents are being used to shape Croydon's implementation of the consultation outcomes.

Croydon's response to the Healthcare for London consultation showed that top changes residents would like to make in the future to improve their health:

- Increase the level of exercise
- Reduce stress
- Improve diet
- Lose weight

Fewer people expressed the following as changes they would like to make:

- Reducing alcohol intake
- Giving up smoking
- Improving sexual health

In relation to maternity, Croydon's response showed the 3 top factors most important to people were:

- Being given choice of home birth
- Giving birth in a midwife led unit with a doctor led unit on the same hospital
- The time taken to travel to the place where the birth will take place

Respondents also indicated they would prefer midwives to see women at home for appointments after the birth of their baby.

Croydon's response showed that there was support for specialist care for trauma, stroke and complex surgery, even if this specialist care was further from their home. This included specialist care for children.

Primary and Community Services Strategy and Urgent Care Strategy

Locally, the first Primary Care Strategy, consulted on during 2007, proposed that services would be arranged in clusters known as Primary Care Centres. Many respondents commented that the proposal did not portray Croydon specifically and requested more information on how the proposed changes would affect their access to services. The PCT agreed to build on the findings of the consultation by working further with health professionals and residents to find the best options.

Service providers and clinicians have been briefed and involved in exploring plans for future services and estate development. In September 2008 market researchers were commissioned to recruit a cross section of 200 Croydon residents to attend deliberative workshops to explore effectiveness of current services and expectations for health and wellbeing. The views of partnership and service user groups have also been invited. Whilst there many experiences of high quality care, levels of service, individual instances of professionalism and a marked degree of gratitude for the local NHS and staff there were other areas which needed improving:

- **Inconsistencies across the Borough** – there was not a universal consistency of quality across Croydon.
- **Getting access to services is not easy** - It seems that access is a key issue for people. People praised where they had experienced efficient and kindly services and staff
- **Doing more locally is a good idea, but get the basics right** – Many people argued for more facilities at local level, for clinics to do more (e.g. minor surgery, blood tests and X-rays)
- **Services are not joined up** – People want a health and social care system that is 'joined up', where staff and organisations work well with each other and across boundaries.
- **Attitudes** – People felt there staff could be unkind, lack in warmth and that people often did not feel treated as a human being.
- **Particular issues concerning urgent care** – There was confusion about what to do if you have a problem 'out of hours'. People also seemed anxious about the

many different possible places you could go for 'minor' health problems or what to do when there is something wrong and you do not know if it urgent or not.

- **Making it better for people from all walks of life** – More needed to be done about for those from 'seldom heard groups'.

The access and service issues will be reflected within the Primary and Community Service Strategy and the Urgent Care Strategy which will be consulted on between January 2009 and March 2009. The issues relating to communication and dignity and respect will also be addressed as priority areas within the communications and patient experience work of the PCT.

Plans for future consultations

There are a number of public consultations expected in implementing Healthcare for London (HfL), the South West London Collaborative Commissioning Initiatives (SWL CCI) and this Commissioning Strategy Plan (CSP) these are outlined as part of Section 4.3.5 which covers the overall impact on consultation.

3.5 Existing targets and local and national health priorities

Croydon Primary Care Trust has consistently achieved financial balance for the past 6 years, and although challenging, a surplus was achieved for 2007/2008. Within this financial context the PCT has continued to improve health and health services. In 2007/2008, the PCT improved its performance against a number of targets through work on service improvement, data quality and additional investment and the Healthcare Commission Annual Health Check relating to 2007/2008 performance again assessed the PCT as good for use of resources and fair for quality of services. However whilst the PCT maintained its performance against existing national targets as 'Almost Met' for two years consecutively, for new national targets there was a slight drop from the position last year of 'Fair' to 'Weak'. The PCT has consistently maintained 'Fully Met' position for the core standards throughout the last three years.

The NHS's priorities and direction for the next 3 year planning cycle were set out in the NHS Operating Framework for 2008/09 and reflected in the PCT's Operating Plan 2008/09, alongside delivery of our local vital signs and CSP. The PCT monitors and reports performance on all the national and local indicators to MT, PEC and Board monthly, including an assessment of risk to future achievement and action plans to improve underperformance. There are a number of areas which PCT is struggling to meet and benchmarked performance against the national and local targets and priorities formed an important part of the process of identifying the PCT's priority outcomes. The position in relation to national priority targets, areas of greatest risk and targets directly linked to our vision and goals are summarised below.

- Infection Control
 - In 2007/08 the PCT succeeded in halving the MRSA infection rate to 24 cases since 2004/05, although it fell short of the Local Delivery Plan target of 22. The PCT continues to progress the reduction of MRSA infections and for 2008/2009 is also making progress against the reduction of C Diff. Infection rates and cleanliness are an important part of the patients experience and will impact upon patient survey results.

- Access
 - The PCT is on track to meet the 18 weeks referral to hospital treatment performance target of 90% for admitted patients and 95% for non-admitted patients. Continuing redesign of care pathways and delivering care closer to home will be a key part of maintaining this position.
 - Although the PCT met the A&E 4 hour target in 2007/08 we are struggling to maintain this in 2008/09 with a year to date position of 97.5% in September. As well as immediate targeted actions, improving and maintaining performance will require a whole system redesign of urgent care.
 - The PCT has commissioned extended hours from 86% of practices. However as described in section 3.3 the PCT needs to improve satisfaction with primary care and access to GPs as measured through the patient survey results, by improving patient experience and enabling wider access to care closer to home.

- All cancers
 - The PCT continues to work with providers, GPs and the south west London (SWL) cancer network to maintain 100% compliance of one month diagnosis to treatment and two month GP urgent referral to treatment

- Choice and Booking
 - Enabling communities and individuals to have informed choice is a key part of the PCT vision. As described in section 3.3 the PCT is not meeting choice and choose and book indicators which are an important part of people's experience.

- Smoking Prevalence
 - As of September 2008, performance on the 4 week smoking quitters is a cumulative actual of 290 from a trajectory of 690 quitters. The PCT has invested to ensure progression against the target by year end 2008/2009 and has a revised action which builds on the recommendations of the London Tobacco Control Support Team. However there remains a high risk of not meeting the target by the end of the year. Addressing this remains a high priority for the PCT and is also an LAA target.
 -

- Teenage Conception:

The provisional teenage conception rate for 12 months to March 2007 is 60 per 1000 against at target of 41.35, which represents a small increase in rate. A comprehensive multi-agency action plan has been developed and this is also an LAA target.

- Sexual Health: In 2007/08 the PCT met the GUM target for access within 48 hours of contacting the service and is maintaining this. However the Chlamydia screening was not met 2007/2008 and for 2008/09, the target has been increased to 15%. As at September 2008 the PCT was achieving 1.7%. Funding has been and put into improving performance which is an important part of addressing the sexual health of young people.

- Immunisation
 - As of September 2008, the immunisation rate for children aged 2 who have been immunised for measles, mumps and rubella MMR is 77.1% from a trajectory of 78.6%. Other immunisation targets are currently being achieved but achieving and maintaining these targets remains very challenging.
 -
- Stroke Care
 - As at September 2008, the proportion of people who spend at least 90% of their time on a stroke unit is 53.3% against a trajectory of 83% and proportion of people who have a TIA scanned and treated within 24 hours is also underperforming. The PCT is investing in acute and community stroke care to improve performance and performance these targets is linked to the PCT, sector and London wide work on improving stroke care.,
- Breastfeeding
 - As at Quarter 2 2008 the PCT actual activity is 59% against a planned activity of 73% on children with a breastfeeding status recorded and 36% against a trajectory of 41% in terms of prevalence of breastfeeding at 6-8weeks... Although currently underperforming the PCT anticipates achieving the target and is investing further to improve the quality and infrastructure of maternity services and is working with partners as this is also an LAA target.
- Mental Health
 - Improving health and well-being is a key part of the PCT's vision. Whilst the PCT is currently meeting all its Mental Health targets, further investment has been made to sustain and improve on performance and the PCT continues to work with its providers to ensure that we improve on drug misusers targets.

3.6 Provider landscape

Health promotion

The delivery of health promotion is multi-agency, multi-disciplinary and multi-faceted. Health promotion initiatives are delivered in a range of settings, from homes and schools, to public spaces and community facilities, to primary and secondary care premises.

The Health Improvement Directorate currently both commissions and provides health promotion initiatives, and also works with primary and secondary care providers to ensure that the health promotion elements of the National Service Frameworks and Quality & Outcomes Framework are effectively delivered. A Health Promotion Resources & Campaigns team are employed to ensure the successful delivery of local and national health promotion campaigns. The role of the community pharmacy in delivering health promotion messages has been greatly strengthened through collaboration with the team. The Health Improvement Directorate also works closely with Croydon Council and the voluntary sector to address the wider determinants of health, and to deliver health promotion through community development. Work is also undertaken with the local business community to promote healthy workplaces, and to encourage employers to take an active role as health promoters. This work is driven in particular through the Healthy Croydon Partnership

and the Social Cohesion and Equalities Partnership as part of the Commissioning Strategy Plan.

All health professionals, and particularly those with regular patient contact, have an important role in promoting health. Further awareness-raising about this universal role, and addressing the capacity issues that might restrict this, remain key priorities.

Primary care landscape

A key strength is the commissioning relationship between the PCT and the Independent Primary Care Contractors, and there are opportunities to develop partnerships between Independent Contractors to facilitate patient pathways, improve access to services and ensure equitable healthcare across sector.

General practice

There are 65 practices in Croydon, 45 PMS practices and 15 GMS Practices - 24 practices (36%) have 4 GPs or more, 30 practices (46%) have two or three GPs and 12 (18%) are single-handed GP practices.

General Practice provides a range of services covering core, additional and enhanced services.

- Additional Services
 - Maternity Services: 65 practices (100%) providing
 - Contraceptive Services: 65 practices (100%) providing
 - Cervical Screening: 65 practices (100%) providing
 - Vaccinations & Immunisations: 64 (98%) practices providing fully
 - Child Health Surveillance: 59 practices (90%) providing
 - Additional Minor Surgery: 59 practices (90%) providing
- Enhanced Services

There are good relationships between clinicians and GPs work in secondary care in a number of specialities. Capacity has historically been increased through the development of enhanced services and GPs with special interests. In some areas of primary care, capacity is limited by the current estate and availability of appropriate clinical facilities within practices. The PCT's primary care strategy will align service delivery and capacity against identified population health need. All practices have signed up to Practice Based Commissioning (PBC) and an incentive scheme is in place. A commissioning plan for the PBC group is in place.

Dentistry

There are 52 practices in Croydon - 49 General Dental Services (GDS); this includes one dental corporate body (Associated Dental Practices), 2 Personal Dental Services (PDS), specialising in the provision of orthodontics on the NHS and 1 PCT Dental Service (PCTDS). This was previously known as the Community Dental Service (CDS), and provides special needs dentistry to the local population. Also, Croydon PCT commissions an Out of Hours dental service at Mayday Hospital.

The introduction of the new dental contract has built good working relationships with local dental practices. Access to NHS dentistry in Croydon continues to be good. There is a commitment to utilise the skills of dentists. The PCT has commissioned additional access sessions from 15 local dental practices. These sessions are

specifically aimed at those patients who have not accessed NHS Dentistry within the previous 2 years. The PCT has also commissioned 5 practices to provide minor oral surgery in primary care.

- Enhanced services - The PCT is commissioning an advanced mandatory dental service in the Intermediate Minor Oral Surgery service. This looks to relieve pressure at Mayday hospital by redirecting patients to primary care facilities.

Optometry

There are currently 36 practices. Approximately half of these are privately run, whilst the other half are made up of companies (Boots, Dolland and Aitchinson, Specsavers, etc).

Optometrists currently participate in shared care activities with Mayday clinicians. There are opportunities to redesign current pathways and open up direct access to cataract surgery. Practice based commissioners have identified optometry referrals as a risk in managing their indicative acute budgets and wish to engage optometrists in service redesign.

Community pharmacy

There are 69 community pharmacies in Croydon - 50 independents, 4 multiples making up 17 individual pharmacies, 2 Essential Small Pharmacy Local Pharmacy Scheme (ESP LPS).

There are further opportunities to use untapped capacity and skills of community pharmacists. However the current facilities do not lend themselves to confidential clinical consultations. Pharmacists are well placed to provide a range of services in the community and can work with other primary care providers to achieve this.

- Advanced services - Thirty four community pharmacies are currently commissioned to provide Advanced Services - Medication Use Reviews (MRUs) and Prescription Intervention Service. Croydon PCT is looking to target specific conditions where we feel patients would benefit from further support in compliance and concordance with medication. The first of these 'targeted' MURs focuses on inhaler technique for asthma patients and was launched in 2007.
- Enhanced services - 51 community pharmacies are currently commissioned to provide Enhanced services. The following Enhanced services are commissioned by Croydon PCT:
 - Supervised Administration Schemes: *methadone and buprenorphine*
 - Needle Exchange Service
 - Smoking Cessation Service:
 - Emergency Hormonal Contraception (under Patient Group Direction): Anti-Coagulant Monitoring Service: Currently 1 pharmacy provider
- *Community pharmacy out of hours service (OOH)* - An OOH service is provided by community pharmacists for urgent prescriptions and advice. The service also holds an agreed stock of palliative care drugs. Further to this one or more pharmacies are commissioned to open for short periods on Public Holidays .

Primary care quality and performance

Of the 65 GP practices participating in the Quality and Outcomes Framework, five practices achieved the maximum 1000 points available and a further five practices achieved the maximum 655 points in the clinical domain. Overall, the average achievement was 949.31 points out of 1000, a percentage achievement of 94.93%. This achievement does not take into consideration the 104.74 points that are deducted from each PMS practice. The achievement is slightly less than 2005/06, where the average achievement was 1001.42 out of 1050, or 95.37%. This year did however see the introduction of nine new clinical areas and higher minimum thresholds for a number of clinical indicators. Six practices signed off their achievement in dispute with the PCT. These cases will be considered by the QOF Quality Panel, and payment will be adjusted if considered appropriate

Community and intermediate services landscape

Community Health Services

Community Health Services are currently mostly provided by the PCT directly. These services have a budget of £36 million, and employ approximately 800 people. The provider arm provides a wide range of services for both adults and children including a number of contracts with private companies in relation to the supply of continence products and wheelchair maintenance.

Services are provided in patient's homes, community clinics, children's centres, Local Authority residential and nursing homes and other settings. Patients are offered services according to clinical need and their mobility, the most vulnerable being provided with comprehensive services in their own homes. The service model uses integration to increase efficiency and capacity, for example generic healthcare assistants who work within both nursing and therapy settings. Increasingly for the most vulnerable, services are co-ordinated using a case management approach. The Virtual Community Wards piloted from May 2006, and now rolled out with 10 'wards' across Croydon, enable patients with long term conditions to be cared for at home by multi-disciplinary teams of health professionals led by community matrons.

By working together with partner organisations to provide integrated health and social care the PCT provides Croydon people with more efficient and responsive services. The PCT has a strong record of collaboration with the Local Authority and has a number of formal agreements that allow better integrated care.

The community services in Croydon are based on close working with General Practices and local pharmacists to provide high quality care as close to patients homes as possible.

They have a strong history of partnership working with other local providers such as social services, the voluntary sector, and Mayday and have therefore developed a number of services jointly. The PCT does not provide any intermediate or community beds. These are currently commissioned in the private sector. PCT community services have a history of innovation and have strong clinical leadership networks. The development of the virtual ward demonstrates the provider services' drive to challenge traditional models of care.

Older People's services are commissioned through a joint commissioning group, which includes representatives from secondary care. The PCT also jointly commissions a number of services with Social Services. There is a Section 28 agreement for integrated Intermediate Care and Section 31 agreements in place in relation to:

- Integrated community equipment service and integrated occupational therapy service.
- Redevelopment of Croydon Council residential homes (New for Old Project)

Whilst there is a relatively low turnover of staff in the community services they are an ageing workforce. This however provides an opportunity to redesign the workforce around skills and competencies to provide a wider variety of care closer to home, although the lack of autonomy affects the speed at which change can happen to meet the patient needs.

Provider services also operate from a number of facilities that range in age and in condition, limiting the flexibility of services that can be provided from them.

- **Provider Arm Strategy**

The White Paper Our Health; Our Care; Our Say set out the ambition for community services to expand and develop safe, high quality services for patients closer to home.

During 2007/08 current directly provided services have been aligned and strengthened to meet the vision of the CSP. During 2008/09 all PCTs were required by the NHS Operating Framework to review the operations and governance of their provider services organisations and to agree a plan for their future development and management. The PCT has almost completed the internal separation required for Community Health Services to function at arms length. A separate committee of the Board, the Community Health Services Committee (CHS), is now established, chaired by a non-executive director. The clinical services are working to a service level agreement which is performance managed by the commissioning team in the same framework as for other providers. The PCT expects to meet the requirements of establishing an Autonomous Provider Organisation (APO) by April 2009.

The work on the separation of the PCT's community health services is being further developed to enable a decision regarding the future form of Community Health Services. The timeline for this is completion by April 2010. As part of the current work across London to strengthen commissioning, an interim proposal has been developed. This centres on the development of a strategic alliance with Wandsworth PCT and Sutton and Merton PCT community health services in order to strengthen provider development. The benefits of this interim solution are as follows:

- It will provide a strong focus for the development of these services whilst, under parallel processes, elements of the commissioning function are also moving towards greater collaboration
- There will be shared learning and the opportunity to complete key pieces of work in a collaborative manner, rather than completing them three separate times.
- It will provide a supportive environment for senior managers at a period of potential uncertainty, reducing the risk of excessive turnover

- This is not a business transfer model, therefore accountability remains with the PCT Board, and there is no requirement to transfer staff.

A list of service line reviews to take this strategic alliance forward is attached in appendix 2. The reviews will be undertaken by February 2009, and consultation on the options will be undertaken between February and June 2009. A Board decision is expected on the future of the CHS in the summer of 2009.

Learning Disabilities

The PCT has joint commissioning in place for learning disabilities, based with the council, with joint accountability. The PCTs total expenditure for 2008/09 is £22 million, of which £7 million is for healthcare and £15 million is for social care. The integrated community team is part of the PCT provider service with the Learning Disabilities psychiatry provision being managed by South London and Maudsley NHS Trust (SLaM). The Learning Disabilities Assessment & Treatment beds are currently provided by Surrey & Borders Partnership Trust and transfer to SLaM in 2009.

The residential care currently provided by Surrey Borders Partnership provides large scale group living instead of individualized approaches in environments that are suitable for some and isolating for others.

As models of social care develop, it has become increasingly evident that the NHS is not well placed to provide high quality, person centred social care, for all aspects of life for clients who need support and care due to disability rather than illness. Croydon PCT, Croydon Council with Surrey PCT and Surrey County Council have established the Social Care Change Programme, to manage the transfer of these services to the independent sector and modernise the way that twenty four hour care is delivered. There are currently approximately 360 residents in Surrey and Borders Homes subject to the Social Care Change Programme, of which 117 are Croydon clients (130 Surrey clients and 113 are from other commissioners).

There is a Section 28 agreement in place to manage the transfer of current resources invested in Surrey and Borders Partnership NHS Trust to independent not for profit, voluntary and private sector providers for the provision of residential care and group home living.

New contractual arrangements and any confirmation of new providers is subject to approval of the high level business case at PCT Board on a contract by contract basis.

Community and intermediate care service quality and performance

Healthcare Commission Annual Health Check 2007/08	Quality of services	Use of resources	Service Reviews
Croydon PCT <ul style="list-style-type: none"> ▪ Urgent Care ▪ Substance misuse ▪ Diabetes ▪ Heart failure ▪ Adult Community mental health 	Fair	Good	Best performing (2008) Excellent (2008) Fair (2007) Fair (July 2007) Fair (2006)

Healthcare Commission Annual Health Check 2007/08	Quality of services	Use of resources	Service Reviews
services <ul style="list-style-type: none"> ▪ Substance misuse ▪ Tobacco control 			Fair (2006) (2006)

Healthcare Commission Annual Health Check 2007/08	Quality of services	Use of resources	Service Reviews
Surrey and Borders Partnership NHS Trust <ul style="list-style-type: none"> ▪ Hospital services for people with acute mental health problems ▪ Adult community mental health services ▪ Substance misuse 	Excellent	Good	Fair Fair (2008) Fair (2006) Fair (2006)

Mental health landscape

The PCT has a total commissioning spend in excess of £51million. The PCT commissions most of its secondary and tertiary mental health services from South London and Maudsley NHS Foundation Trust (SLaM) except for a residual element of forensic services which will continue to be provided by South West London and St George's NHS Mental Health Trust and the independent sector. All secondary Child and Adolescent Mental Health Services, Adult Mental Health, and Mental Health Older Adult community services are fully integrated with Croydon Council's services. The PCT commissions the independent Priory Group to provide primary care psychological therapy services across Croydon. Priory therapists work in up to 25 community settings, including GP practices, to deliver a wide range of evidence-based individual, group and computer-assisted therapies for conditions including depression, anxiety, panic and obsessive compulsive disorders, and phobias.

South London and Maudsley Foundation Trust (SLaM) has scored well to date on "Standards for Better Health" and other Healthcare Commission reviews although the scores in the 2007 patient survey were below the national average. For a number of years the Trust has managed an increasing integration of health and social care services, carrying responsibility for Croydon Council funded staff and resources in the whole age range of local mental health services. A recent review and re-organisation of local adult services has brought improved functioning between parts of the overall service and Croydon has good access to the Trust's nationally recognised specialist services. SLaM has a strong record in encouraging the involvement of service users and carers in the development and delivery of services.

The PCT contracts 26 mental health providers within the third and voluntary sector. These services range from primary care psychological therapies through to social inclusion services supporting health well-being and social care. Key providers include The Priory, MIND in Croydon and Care UK. The PCT undertook a review of mental health day service and social inclusion services in 2008 and this will lead to a series of re-commissioned services with statutory and third sector providers following the completion of the tender and procurement exercise currently underway. It is expected that new services will be commissioned from April 2009.

Mental Health Trusts quality and performance

Healthcare Commission Annual Health Check 2007/08	Quality of services	Use of resources	Service Reviews
South London and Maudsley NHS Trust * <ul style="list-style-type: none">▪ Adult Community Mental Health Services▪ Substance Misuse Services	Excellent	Excellent	Fair (2006) Good (2006)
South West London and St George's MH Trust <ul style="list-style-type: none">▪ Hospital services for people with acute mental health problems▪ Adult community mental health services▪ Substance misuse	Good	Good	Fair (2008) Fair (2006) Good (2006)

* Main provider for Croydon

Secondary and tertiary care landscape

The PCT commissions acute services through a portfolio of 24 service level agreements (SLA) and Foundation Trust contracts with a total value of £191 million - seven are NHS Foundation Trusts and 18 are within the NHS London area.

In line with the PCT's agreed approach to market management and procurement clinical pathways are continually reviewed to assure compliance against best practice, strategic fit with CSP goals and value for money. To support this approach Practice Based Commissioning is providing the means to redesign clinical pathways based on current evidence, clinical guidance, quality standards and good practices in clinical service areas. Driven by 'Our Health Our Care Our Say' the PCT has developed its strategic approach to ensure primary care and community care is developed to support the 'front end' and 'back end' of the redesigned pathways. To support the primary care and community care infrastructure there are a number of capital schemes in progress. There are three major business cases for Purley Hospital, Parkway Health Centre and Croydon General, currently under development.

The PCT has led work across South West London to decommission procedures which are not clinically effective and to set criteria for access to others. This has supported demand management assumptions and released funds for reinvestment in other areas.

Mayday Healthcare NHS Trust

The PCT's main acute provider is Mayday Healthcare NHS Trust with an acute SLA value of £120 million in 2008/09. Mayday has a large and busy A&E department with approx 120,000 attendances a year, a GUM clinic with approx 25,000 attendances per year and an obstetric unit with in excess of 4,500 births per year and a new midwife led birthing unit. Approximately 80% of Mayday's acute activity relate to Croydon residents, which equates to about 67% of the PCTs acute commissioning budget. Croydon acts as the co-ordinating commissioner for Mayday on behalf of all London and Surrey PCTs.

During 2008/09 Mayday has not been able to meet the national standard on treatment in A&E within four hours. Current performance is 97.5% (April to September 2008) and an action plan is in place to recover this position. For elective services there were no breaches against the national standards on the in-patient and out-patient waits. The Trust met its 2007/08 milestones on the proportion of people treated within 18 weeks and is projected to meet the national targets by December 2008. The Trust is also on track to meet its targets on healthcare acquired infections. In the Healthcare Commission inpatient survey published in May 2008 the Trust was rated in the lowest quartile nationally. Following the implementation of the agreed action plan local monitoring data shows an improvement in patient experience.

Other providers

Other significant providers are the South West London sector Trusts, St Georges Healthcare NHS Trust (£16 million), Epsom and St Helier University Hospitals NHS Trust (£13 million), and The Royal Marsden NHS Foundation Trust (£10 million).

St Georges is Croydon's main provider of tertiary services (although significant specialty based work is undertaken at Guys and St Thomas' and Kings College Hospitals). Epsom and St Helier provide core services plus renal and lower limb orthopaedic services at South West London Elective Orthopaedic Centre and the Royal Marsden provides cancer services. Outside of sector the majority of service level agreements are for the provision of tertiary services (Guys, Kings, Royal Brompton, Great Ormond Street) and the nearer hospitals are accessed by patients exercising choice (Bromley, Surrey and Sussex, Kings).

Secondary care and tertiary quality and performance

Healthcare Commission Annual Health Check 2007/08	Quality of services	Use of resources	Service Reviews
Epsom and St Helier University Hospitals NHS Trust <ul style="list-style-type: none"> ▪ Maternity ▪ Admissions Management ▪ Diagnostic Services ▪ Medicines Management ▪ Service for Children in Hospital 	Good	Fair	Least well performing (2008) Fair (2006) Good (2006) Fair (2006) Fair (2006)
Kingston Hospital NHS Trust <ul style="list-style-type: none"> ▪ Maternity ▪ Diagnostics Services ▪ Medicines Management ▪ Service for Children in Hospital ▪ Admissions management 	Good	Excellent	Least well performing (2008) Good (2006) Fair (2006) Good (2006) Weak (2006)
Mayday Healthcare NHS Trust * <ul style="list-style-type: none"> ▪ Maternity ▪ Admissions Management ▪ Diagnostic Services ▪ Medicines Management ▪ Service for Children in Hospital 	Fair	Fair	Least well performing (2008) Weak (2006) Fair (2006) Weak (2006) Fair (2006)

Healthcare Commission Annual Health Check 2007/08	Quality of services	Use of resources	Service Reviews
St George's Healthcare NHS Trust <ul style="list-style-type: none"> ▪ Maternity ▪ Admissions Management ▪ Diagnostic Services ▪ Medicines Management ▪ Service for Children in Hospital 	Good	Fair	Least well performing (2008) Fair (2006) Good (2006) Good (2006) Fair (2006)
The Royal Marsden NHS Foundation Trust <ul style="list-style-type: none"> ▪ Medicines Management ▪ Service for Children in Hospital 	Excellent	Excellent	Good (2006) Good (2006)
Guys and St Thomas' NHS Foundation Trust <ul style="list-style-type: none"> ▪ Maternity ▪ Admissions Management ▪ Diagnostic Services ▪ Medicines Management ▪ Service for Children in Hospital 	Good	Excellent	Better performing (2008) Fair (2006) Weak (2006) Excellent (2006) Good (2006)
Kings College Hospital NHS Foundation Trust <ul style="list-style-type: none"> ▪ Maternity ▪ Admissions Management ▪ Diagnostic Services ▪ Medicines Management ▪ Service for Children in Hospital 	Fair	Excellent	Fair performing (2008) Fair (2006) Good (2006) Good (2006) Fair (2006)

* Main provider for Croydon

Specialist services landscape

Specialised Services are commissioned on behalf of London PCTs through the London Specialised Commissioning Group (LSCG) and Local Specialised Commissioning Groups (LSCG). NHS London has agreed that to avoid unnecessary duplication, London SCG will submit a Commissioning Strategy Plan for all areas of specialised commissioning currently contained in the London SCG Health Delivery Plan. In 2008/09 this covered 16 specialised services which are commissioned at a pan London or pan Thames level, including the Pan Thames Haemophilia Consortium, which is hosted by Croydon PCT.

Croydon is the lead PCT for specialised commissioning for the five PCTs in the South West London sector. The Specialised Commissioning Team manages the Pan-Thames Haemophilia Consortium, which constitutes 48 PCT members and covers 10 acute trusts with a turnover of £100 million, and also leads on neonatal intensive care and HIV services. The PCT has recently agreed to become the host PCT for London Specialised Commissioning from April 2009.

3.7 Financial situation

The PCT has met all its financial duties since it came into being in 2002/03 and has scored a consistent 3, good, in its ALE score since ALE was first introduced. In particular it is one of a small number of PCTs, reorganisations included, that consistently scores a 3, good, for value for money.

Programme budgeting analysis was commissioned from the Audit Commission for 2002/03 and 2005/06 and used to a limited extent in financial planning. For this CSP the PCT's finance and public health departments have undertaken a more sophisticated analysis, based on work done at North Yorkshire and York PCT, mapping programme budgeting data, against outcomes and inequalities. From a financial perspective the following analysis has resulted:

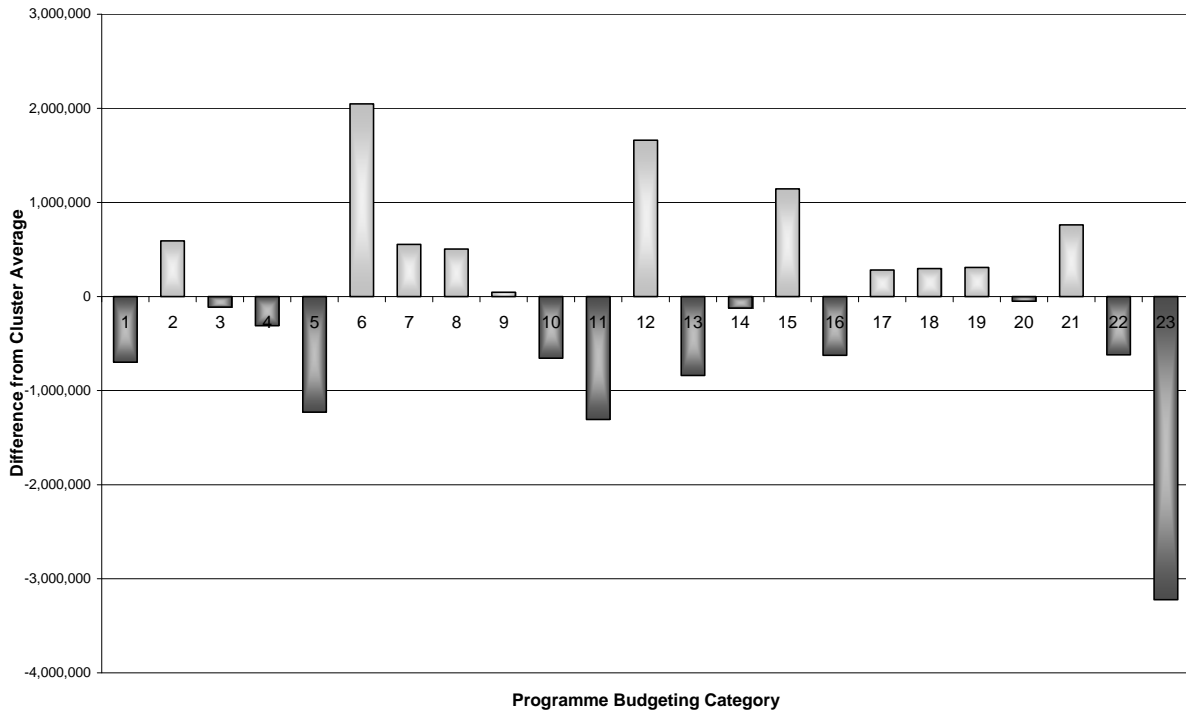
Where did Croydon PCT invest its money, in all the major programmes in 2006/07, and how does that compare with elsewhere?

Programme budget category	Croydon	Cluster	London	England
1 Infectious diseases	£2,206,000	£2,904,000	£4,764,000	£2,141,000
2 Cancers and tumours	£7,721,000	£7,129,000	£6,902,000	£8,087,000
3 Blood disorders	£1,988,000	£2,100,000	£2,089,000	£1,648,000
4 Endocrine, nutritional and metabolic problems	£3,428,000	£3,737,000	£3,502,000	£3,638,000
5 Mental health problems	£17,426,000	£18,655,000	£21,423,000	£16,392,000
6 Learning disability	£7,132,000	£5,084,000	£4,580,000	£4,625,000
7 Neurological system problems	£5,157,000	£4,603,000	£4,850,000	£5,474,000
8 Vision problems	£2,601,000	£2,096,000	£2,156,000	£2,682,000
9 Hearing problems	£451,000	£406,000	£445,000	£615,000
10 Circulation problems	£10,366,000	£11,021,000	£10,477,000	£12,112,000
11 Respiratory system problems	£4,804,000	£6,111,000	£5,872,000	£6,465,000
12 Dental problems	£5,331,000	£3,668,000	£4,148,000	£4,426,000
13 Gastrointestinal system problems	£6,287,000	£7,126,000	£6,455,000	£7,285,000
14 Skin problems	£2,616,000	£2,738,000	£2,595,000	£2,810,000
15 Musculoskeletal system problems (excl. trauma)	£6,613,000	£5,470,000	£5,312,000	£6,552,000
16 Trauma and injury	£4,754,000	£5,379,000	£4,757,000	£5,682,000
17 Genitourinary system problems	£7,250,000	£6,968,000	£6,839,000	£6,848,000
18 Maternity and reproductive health	£6,083,000	£5,786,000	£6,183,000	£5,716,000
19 Neonatal conditions	£1,859,000	£1,549,000	£1,908,000	£1,308,000
20 Adverse effects and poisoning	£1,252,000	£1,302,000	£1,384,000	£1,451,000
21 Healthy individuals	£2,385,000	£1,622,000	£2,370,000	£2,517,000

Programme budget category	Croydon	Cluster	London	England
22 Social care needs	£2,346,000	£2,966,000	£2,526,000	£2,323,000
23 Other areas of spend	£18,916,000	£22,138,000	£21,946,000	£20,657,000
Total	£128,970,000	£130,560,000	£133,482,000	£131,454,000

This can be summarised as follows:

PCT cluster variance per 1,000 population, Croydon, 2006/7



This is a summary of a 108 page report which takes the costs and maps against outcomes and inequalities to identify, within limitations of the finance and outcomes data, a variety of scenarios from high cost, high outcome to low cost, low outcome.

Examples of the conclusions that fed into the Joint Strategic Needs Assessment and this Commissioning Strategy Plan are:

- Dental programmes (programme 12) – high cost but reflects higher level of NHS coverage compared to average, budget ring fenced by DoH but ring fencing ending, no decision to disinvest.
- Learning disability (programme 6) – high cost, prevalence in line with English average but distorted by Old Long Stay which accounts for all the difference, social care budget transferring to local authorities. Last year and this year's CSPs Commissioning Strategy Plans looking to disinvest in institutionalised care and invest in more client centred care and to be achieved within existing funding.
- Respiratory system problems (programme 11) - low cost, poor outcomes for pneumonia and asthma SMRs and resulting in agreed investment in this CSP.
- Mental health problems (programme 5) – low cost, outcome data not well developed, but prima facie evidence of underinvestment. Priority in Joint

Strategic Needs Assessment and additional investment in mental health prioritised.

Last year's PCT Commissioning Strategy Plan, flowed through into the 2008/09 Operating Plan, identified a plan for investment and disinvestments and also included surpluses and contingencies to fund future year recurrent and non recurrent developments. This mostly covered proposed developments that were subject to public consultation under Healthcare for London, pressures from future NHS Operating Frameworks and other PCT strategies that were still under development.

In 2007/8 The PCT achieved a £2.6 million surplus and plans to achieve a £6 million surplus in 2008/09 i.e. an increase of £3.4 million. In formulating its 2008/09 plans the PCT was reliant upon achieving £3.9 million of demand management initiatives and £2 million of cost improvements i.e. schemes outside of the 3% of efficiency savings built into tariff, pay and price uplifts.

During 2007/08 the PCT pioneered the use of turnaround processes in an organisation not subject to turnaround, this has now been published and adopted elsewhere in the NHS. Through the use of PWC as turnaround consultants and a director recruited from the PWC turnaround panel the PCT established a Programme Management Office (PMO) that establishes standard documentation and programme management disciplines for demand management and cost improvement schemes. For 2008/09 the PMO was extended to cover some of the 2008/09 Operating Plan schemes arising from the previous Strategic Commissioning Plan. The PMO feeds into the PCT's performance management system and provides support to project managers. It is an advisory and performance reporting service of 1.2 members of staff that does not remove the responsibility for performance management delivery from PCT directors and the Board.

Current in year performance at Month 6 FIMS, following quarter 1 freeze and flex, indicates that the PCT is on track to meet its planned surplus of £6 million with its contingency meeting unplanned non elective activity/demand management slippage and continuing care pressures. The table below indicates the m 6 position as reported to the PCT Board.

Croydon PCT Month 6 Position Surplus/(Deficit)	Annual	September 2008 - Month 6			Year End	Year End
	Budget	Plan	Actual	Surplus/ (Deficit)	Outturn	Outturn
	£000	£000	£000	£000	(M6) £000	(M5) £000
Strategic Commissioning						
- acute	191,620	95,810	100,060	(4,250)	(7,200)	(7,122)
- acute specialist	16,637	8,290	8,285	5	0	75
- mental health	51,175	25,587	26,245	(658)	(850)	(575)
- learning disabilities	21,551	10,776	10,202	573	1,000	1,000
- other	29,827	14,820	14,780	39	(900)	(1,100)
Community Health Services						
- Provider Services	36,173	17,692	17,541	302	685	685
Primary Care Commissioning						
- Medical & Dental Services	62,576	30,442	30,184	258	700	700
- Prescribing	41,295	20,648	19,969	678	1,750	1,750
- Pharmacy Contract	2,134	1,067	1,028	39	(1,290)	(1,290)
Corporate Directorates	11,229	5,191	5,152	39	350	350
Reserves						
- Contingency	3,000	1,500	0	1,500	418	190
- Surplus	6,000	3,000	0	3,000	6,000	6,000
- Agreed Developments	4,756	844	0	844	1,687	1,687
- Other Committed Reserves	7,581	2,925	2,181	744	3,650	3,650
TOTAL Revenue	485,554	238,590	235,628	3,114	6,000	6,000
Capital	1,377	556	556	0	0	0
TOTALS Revenue and Capital	486,931	239,146	236,184	3,114	6,000	6,000

The table above identifies the current in year performance and although indicates that there is a significant overperformance in acute services, the PCT's reserves, which include £5 million of contingencies to cover the estimated in year cost pressures on commissioning, plus other variances on commissioning bring about the £6 million plan surplus. One of the major lessons learned was the new complexity of procuring changes in commissioned services under the PCT Procurement Guide, issued in May 2008, and services have been competitively tendered where appropriate since that date. In addition the PCT has identified capacity and capability gaps, particularly in project management. Over this period the PCT has therefore invested more resources in directorate project managers and continues to learn and develop better and smarter ways of delivery, though recognises there are still internal issues around delivering change at a rate previously unknown in the NHS. IT has also taken account of the past year's experience in planning its future investments and investments in building in realistic lead times and adopting a more rigorous approach to project planning.

3.8 Activity commissioned

The PCT's commissioning of acute activity in 2007/08 was focused on the delivery of the 2007/08 NHS Operating Framework within the context of the NHS Plan targets.

For 2008/9 the PCT commissioned to ensure it fully meets the 18 week target. Demographic, prevalence and planned changes were also commissioned in line with the last year's commissioning strategy and operating plans. This included a significant amount of activity closer to the patients home, mainly via GP led outpatient services (including gynaecology, dermatology, ENT and gastroenterology) along with a number of key initiatives to improve the health and well being of the people of Croydon (e.g. smoking cessation, weight management, school nursing and immunisation). Full details are included in finance and activity template. As far as non acute activity is concerned the main areas with planned increases in commissioned activity have been forensic placements; continuing and funded nursing care; BME workers and crisis intervention services in mental health; GUM services; specialised commissioning (haemophilia, HIV/AIDs/BMT etc.); audiology and NHS dentistry. In order to manage uncertainty the PCT has a contingency available for activity not known at the time of the plan. An example of this is 2008/09 unplanned increased transfer of patients from the criminal justice system to the NHS.

The 2007/08 and 2008/09 baseline positions, where measurable, is summarised below:

Activity	2007/08 Actual	2008/09 Forecast
Elective inpatient and day case spells	35,070	35,491
Non elective and emergency spells	34,182	34,623
Outpatient attendances	317,013	314,047
A and E attendances	117,525	123,041
Ambulance journeys	31,412	32,226
Walk-In-Centre attendances	29,514	29,809
Dental UDAs	472,158	490,126

The estimated impact of demand management schemes is given below:

2008/09 Demand Management Schemes	Impact on Activity 2008/09
Outpatients	-12,461
Non-elective spells	-568
Elective spells	0
Other (promary/community care contacts)	12,155
Total A&E Attendances	0

The 2008/09 in year position has seen an increase in GP referrals, A and E attendances, non elective activity and non PBR activity, though contained within the PCT's contingency and other available funding. Some of this increase is similar to other parts of the NHS in and out of London and there is no prima facie evidence that Croydon is an outlier.

3.9 Primary and community services strategy

In 2007 Croydon Primary Care Trust consulted people in Croydon on plans for a new strategy for primary care. The key themes that came out of the consultation were:

- A request for more detailed information on health needs to inform decisions
- Further work on the development of a model of primary care for the PCT
- Link the primary care strategy with the health needs of local populations
- Increase stakeholder involvement in service planning and design
- Demonstrate associated funding implications

The PCT therefore began revising the strategy in line with these key themes. Between December 2007 and March 2008 the PCT participated in the Healthcare for London consultation, consulted on proposals to improve Londoners' healthcare over the next 10 years and ensure equitable delivery of healthcare across the capital.

Throughout 2008, the PCT has been working with the public and partner organisations to further develop the findings and recommendations from the two consultations. A further formal consultation will take place between January and March 2009 about a framework for Primary Care, Community Services and Urgent Care. It will not be about any individual service or building. Its proposals focus on services from a patient's point of view, what needs to change to make services safer and more accessible and to make Croydon residents healthier. It will propose 6 hubs and primary care networks including one GP led health centre. It is expected that the GP led health centre will be open by March 2010, with 1 network to be established by March 2010/11, 2 networks to be established by March 2011/12 and the remaining 2 networks to be established by 2012/13.

Case for change

The capacity and capability within primary and community services to accommodate the shifts from secondary care, in terms of work force skills and adequate estates will be addressed as the new models of care are developed and implemented. The strands of work underpinning the redesign of local primary care and community services aim to:

- Match services to community needs and provide more services closer to where people live.
- Where necessary provide specialist services at centres of excellence
- Take account of access, local transport links and travel issues.
- Build on existing local partnerships and where local professionals work together.
- Make the most of the workforce skill and capability

As part of the Healthcare for London consultation, Croydon residents agreed they would like their GPs to be open for longer hours, and over half said that almost all GP practices should be part of a wider network for health and social care. The draft Primary and Community Service Strategy supports the delivery of the local view.

The vision for primary and community services

The vision for primary and community services is to provide services as close to people's homes as possible, yet recognising when specialist facilities are required and economies of scale will lead to improved service provision within a specific clinic/community based setting. This will support the 5% year on year shift of secondary care activity to primary care over the next 5 years.

This covers services provided by GPs, community and practice nurses, community therapists (such as physiotherapists and occupational therapists), community

pharmacists, optometrists, dentists and midwives. Every person should have the best possible access to these services.

We will develop services that focus on prevention as well as cure. Improving health and reducing the health inequalities in Croydon will only be achieved by focusing on a needs based model of planning and delivering services and working with other organisations.

Where necessary services will be grouped or co-located to facilitate:

- Seamless diagnostics with reduced patient waiting and visits
- Delivery of pre-determined evidence based treatment and care pathways
- Delivery of treatment and care pathways that are fully integrated for patients with multiple or complex conditions

The primary care and community strategy seeks to deliver services by need and within population clusters. Within each population cluster the need for urgent care services will be evaluated and options around provision of urgent care services across the clusters will be formulated.

Formal Consultation on both the Urgent Care Strategy and the Primary and Community Services Strategy is planned for January 2008 – March 2009.

A key enabling strategy which supports the delivery of the primary and community vision is the Estates Strategy (see section 5.5.7). The PCT is currently a key partner in three major capital projects; Croydon General, Parkway Health Centre and Purley Hospital.

Developing services in line within Healthcare for London

The Healthcare for London consultation undertaken in 2008 consulted Londoners' on principles to underpin equitable delivery of healthcare across the capital. The consultation also focused on how to deliver access to care and how to provide more GP services, tests, clinical specialists and urgent care in the community. This London-wide consultation did not replace the need for local discussion and working through what is best for Croydon in terms of strategic development in primary and community care in line with the London principles. We need to continue working to ensure we fit in with the London principles. The local work here in Croydon is focused on:

- Identifying existing partnerships and service configurations that work well and deciding how to incorporate these into future plans for primary care and delivering services in line with local population health needs.
- Using the available health intelligence information to review and set out new options for delivering equitable services in primary care.

People shaping services

In 2007 the PCT consulted people in Croydon on plans to reshape the way primary health care services are provided across the borough. The proposed Primary Care Strategy focused on changes to develop services to meet people's future health care needs.

The primary care strategy proposed that services would be arranged in clusters known as Primary Care Centres. Many respondents commented that the proposal did not portray Croydon specifically and requested more information on how the proposed changes would affect their access to services. The PCT agreed to build on the findings of the consultation by working further with health professionals and residents to find the best options.

Service providers have been briefed and involved in exploring plans for future services and estate development. In September 2008 market researchers were commissioned to recruit a cross section of 200 Croydon residents to attend deliberative workshops to explore effectiveness of current services and expectations for health and wellbeing. The views of partnership and service user groups have also been invited. Whilst there many experiences of high quality care, levels of service, individual instances of professionalism and a marked degree of gratitude for the local NHS and staff there were other areas which needed improving.

The outcome of the workshops was outlined in section 3.4. Access and service issues will be reflected within the Primary and Community Service Strategy and the Urgent Care Strategy which will be consulted on between January 2009 and March 2009. The remaining issues relating to communication and dignity and respect will be addressed as priority areas within the communications and patient experience work of the PCT.

Designing services in line with population health needs

The GP-led health centre in Croydon will be the first element of service to be opened as part of a prototype networked service model. The health centre will form a hub of the first new service model serving a population cluster (71,000 residents) near East Croydon station and south towards Broad Green, Waddon and Croham and will be open by March 2010.

3.10 Conclusion

In reviewing the internal and external environment the PCT has considered:

- the JSNA and other demographic and health needs information including forward projections
- programme budgeting, world class commissioning and other benchmarking
- patient experience
- patient, stakeholder and public feedback
- performance against key local and national targets
- knowledge of current services
- national and London policy frameworks
- locally developed strategies (including the previous CSP)

We have used this information to develop the priority outcomes, goals and initiatives as set out in the next chapter. Together they provide a strategic framework for commissioning in Croydon for the next 5 years focused on the needs and priorities of local people which will improve health and reduce inequalities.

SECTION 4 – STRATEGY: OUTCOMES, GOALS AND INITIATIVES

4.1 Outcomes

The commissioning strategy plan and its supporting strategies enable the PCT focus on its priorities, set clear targets and be able to measure progress.

The PCT has ten priority outcome measures focused on understanding the needs of our population and strategic priorities:

- Life expectancy at birth
- Health inequalities
 - Average Index of Multiple Deprivation (IMD) score
- Low Birth weight:
 - Live and stillbirths where babies have weighed less than 2500grams
- MMR:
 - Children aged 2 who completed immunisation for MMR
- Childhood obesity:
 - Children in Year R with height and weight recorded who are obese.
- Teenage conception:
 - Teenage conception rate per 1,000 females aged 15-17
- Diabetes controlled blood sugar:
 - Patients with diabetes who have an HbA1c of 7.5 or less
- Breast cancer screening:
 - Coverage of women aged 53-64 (less than 3 years since last test)
- Chronic obstructive pulmonary disease:
 - Deaths from bronchitis, emphysema and other chronic obstructive pulmonary disease (COPD) for all ages
- Self reported experience of patients and users:
 - Patient experience score

These were selected following several prioritisation stages. A range of outcome data was initially reviewed identified through analysis of:

- the Joint Strategic Needs Assessment dataset indicators,
- the 54 indicators provided in the World Class Commissioning Assurance Handbook and
- the programme budgeting work.

As part of this initial review the PCT agreed to focus on areas where Croydon was performing significantly below the national average which identified a potential 22 outcomes.

The Board and Professional Executive Committee then individually prioritised the 22 outcomes based on agreed criteria. The criteria was developed using the PCT's public health department and prioritisation criteria developed by the NHS Institute for Innovation and Improvement. The Board and PEC agreed the criteria as:

- Improves the health of many people
- Addresses significant inequalities locally
- Addresses local priorities
- Demonstrates value for money (economic health benefits relative to investment)

In addition to the Board and PEC's prioritisation process, an event was held on 24 September 2008, to ask stakeholders to prioritise the top 8 outcomes. They were asked to do this based on their knowledge of Croydon.

The Board and the PEC then reviewed the outcome of the stakeholder event against the outcome of Board and PEC's prioritisation process.

The 8 outcomes were selected to address the range of priority issues for the PCT and which had maximum impact over the life of the commissioning strategy plan including a range of health outcomes, health outputs and health inputs.

appendix 3 provides some further detail to the 10 outcomes selection.

4.2 Strategic Goals

The picture described in the context provides clear reasons why Croydon's NHS needs to change and the outcome measures set out our priorities for action. We must look to a wider range of solutions to address the need for change. In this section we set out the seven strategic goals that we will have delivered by 2013 with a summary of the case for change. This is followed by a table showing the CSP and CCI initiatives to address these goals and a table summarising how together these goals will address Croydon's priority health outcomes.

Goal 1 Improving health and reducing inequalities

By 2013, we will improve health and reduce inequalities by focusing on the areas of greatest potential health gain: children & young people and smoking and on key determinants of health improvement and inequalities.

Summary of the case for change

Croydon has more children and young people and more schools than any other London borough. Focusing on prevention and health promotion activities for children, including immunisation and teenage pregnancy, will affect more years of life and will contribute to breaking the generational cycles of poor health. Smoking is the single largest cause of premature death and the greatest identifiable contributor to inequalities in health and life expectancy. Stopping smoking at any age improves health and increases life expectancy. Being overweight increases the risk of developing lifelong conditions such as diabetes, heart disease, and high blood pressure, all of which can significantly reduce life expectancy, as well as having a major impact on quality of life. As well as addressing key health outcome challenges for Croydon this goal reflects issues within the Healthcare for London Staying healthy and children and young people priorities.

Goal 2 Long term conditions: prevention, treatment and care

By 2013 we will improve the quality of life for people with long term conditions, through designing a whole system model with generic pathways with increased self care, reduced urgent care and increased provision of planned responses.

Summary of the case for change

Long term conditions place considerable demands on Croydon's health services. There are currently an estimated 2,900 patients with diagnosed COPD, 8,900 with diagnosed CHD, and 15,000 with diagnosed diabetes. Almost one in four of the

population aged 65+ has more than one chronic condition. The prevalence of long term conditions will increase in line with the projected increases in the numbers of older people and numbers of people from ethnic groups with above average levels of diabetes and hypertension risk due to projected changes in the ethnic mix of the local population. Increasing levels of obesity among the population will also contribute to increased risk of long term conditions. Data from general practice in Croydon suggests there may be under-diagnosis or under-recording and potential for improvement in the management of long term conditions, including diabetes, COPD and CHD.

Nationally and locally the incidence of cancer is increasing as people live longer, more people are alive having survived cancer, there are new opportunities for early diagnosis (genetics; screening; diagnostic technologies) and there is considerable potential to introduce new service models to improve convenience and outcomes for patients and to deliver value for money. Croydon has the highest breast cancer mortality rate among 50-69 year olds in England and above average mortality rates for stomach, cervical, prostate cancer and leukaemia.

This goal also reflects Healthcare for London priorities regarding diabetes and vascular strategies, cancer screening and end of life care, and sector work on renal services.

Goal 3 Care closer to home

By 2013 we will have models of care and deliver services designed around the needs and preferences of local people, which provide services closer to home where possible and centralised where necessary based, on quality and expertise.

Summary of the case for change

Acute hospitals should be places where people go when it is necessary, not as a matter of routine. There, therefore needs to be a fundamental shift to provide care geographically closer to home where quality, safety and value allow whilst grouping services to ensure timely access to specialist expertise as necessary. Experience of remodelling pathways of care by improving access and expertise in primary and community care has allowed the removal of unnecessary steps and has improved patient satisfaction while delivering best practice and best value.

As well as redesign of key patient pathways this goal addresses our primary and community services and urgent care strategies and is linked to the sector and London wide work on stroke, major trauma and unscheduled care and paediatrics.

Goal 4 Maternity: Quality, Access, Choice

By 2013 we will improve the quality and infrastructure of maternity services and ensure that all women have choice about the maternity care they receive, together with improved access to services and continuity of midwifery care and support.

Summary of the case for change

There is emerging evidence in of above average, and increasing, rates of perinatal and infant mortality. Low birth weight is a major risk factor for infant and perinatal death and low birth weight babies experience poorer health outcomes throughout their lives. The Healthcare Commission Maternity Survey rated Mayday were rated in

he 20% least well performing Trusts in the country for clinical focus, efficiency and capability. Perinatal audit data from Mayday Hospital shows that in 2003-05, 23% of births were delivered by caesarean section, and that 40% of these were planned caesareans. Currently, just 2% of births to Croydon mothers are home births. The goal is linked also to Healthcare for London and sector work on maternity and neonatal care.

Goal 5 Learning disability: Social care change programme

By 2013 we will improve services and promote independence for people with learning disabilities through the delivery of the social care change programme which will reprovide services for clients currently in community homes.

Summary of the case for change

Currently 121 clients are supported across residential care homes and group homes across east Surrey and Croydon. The style and nature of service provision has not kept up with the changing needs of existing service users and will not meet the needs of future generations. The social care change programme will enable future service to be individually tailored, planned and developed using a person centred approach. The programme is essential because the current service provision is outdated. It provides large-scale group living instead of individualised approaches and is being delivered in environments that are unsuitable for some and isolating for others. This goal is a specific local priority and will significantly improve the experience of current clients.

Goal 6 Mental health and well-being

By 2013 we will improve the mental health and well being of the local population, by ensuring services are organised and delivered to better meet people's needs, especially those of vulnerable groups, and by working with other partners to promote mental wellbeing in the community at large.

Summary of the case for change

At present, one in six adults is suffering from a mental health problem. Over the course of a year, one in four people will have experienced a mental health problem. Mental illness can be extremely debilitating, and is the most common cause of sickness absence. People with severe mental health problems suffer from poorer health, and have a significantly lower life expectancy compared with the general population. Severe mental illness only accounts for a small proportion of mental health problems, with anxiety and depression being the most common disorders in the UK population

The suicide mortality rate for Croydon is close to the England average. However, acute inpatient admissions for mental health problems have increased over the past three years with the most significant increases locally being for common mental disorders, which could be diagnosed and treated within primary care. Nationally, less than a quarter of people with anxiety disorders, and a third of people with depression, are receiving treatment. This goal also addresses requirements as part of the Healthcare for London consultation and reflects the local feedback last year that mental health services should be included as one of our priority areas.

Goal 7 Patient Experience

By 2013, we will improve people's experience of health and healthcare through systematic use of feedback, engagement and patient experience data throughout the commissioning cycle.

Summary of the case for change

Findings from surveys of patients and recent engagement initiatives show that people in Croydon do not receive adequate quality of treatment and report poor experiences of accessing and using services. The PCT has also conducted numerous engagement initiatives to find out the views of patients, carers and the public. For example, recent listening events with members of the public as part of our efforts to improve primary and urgent care reveal inconsistencies in quality of care and particular problems regarding access and communication. The goal reflects also the Healthcare for London theme of personalisation of services.

Prioritisation

These seven strategic goals are based on delivering the priority health outcomes and the PCT's vision. There are two main themes – increasing prevention/health promotion and developing specific models of care for the future. The goals and the initiatives to deliver them build on the strategic direction set out in Our Health, Our Care, Our Say and the themes of Healthcare for London and the Next Stage Review, including developing primary care infrastructure and care closer to home, increasing independence, reducing reliance on institutional care and also building on our local priorities.

The first Commissioning Strategy Plan and the foundations of this refreshed CSP reflect discussions with stakeholders including two stakeholder events held during November 2006 and June 2007. These discussions considered the Croydon vision, considered information on population health needs and performance and identified priority areas that were developed into the six strategic goals and the initiative areas. During 2008 the six goals were reviewed in the context of:

- Delivering the ten priority outcomes
- Healthcare for London
- Local engagement and consultation over the preceding year
- Next Stage Review

Many of the goals and initiatives in the original CSP were aligned with delivery of the ten outcomes. Revisions were made to address better the PCT priority areas including the addition of goals for Mental Health and Well-Being, and Patient Experience. As part of the refresh we recognised that the achievement of a financial surplus was an enabling strategy to support delivery of our goals.

The table below sets out the CSP goals and the CSP initiatives and the South West London Collaborative Commissioning Initiatives to deliver these goals. The initiatives are summarised in section 4.3 with full details in appendix 5.

CSP Goal	CSP Initiative	CCI Initiatives
Improving health and reducing inequalities	Children and Young People Smoking Healthy Weight, Healthy Lives	
Long term conditions: prevention, treatment and care	A Whole System Approach: long term conditions, disease focus, (diabetes, COPD, vascular), End of Life Cancer	Renal Cancer
Care closer to home	Planned Care Urgent Care GP Led Health Centre and Primary Care Networks	Paediatrics Major Trauma Stroke
Maternity: Quality, Access, choice	Promoting Birth as a Normal Event High Quality Maternity Services	Maternity Neonatal Intensive Care
Learning Disabilities : Social Care Change Programme	Social Care Change Programme	
Mental Health and well being	Mental Health and Well Being Mental Health Services	Mental Health
Patient Experience	Patient centred improvement	

Delivery of Health Outcomes

The table below summarises how the goals together will deliver the ten priority outcomes. The indicators for the collaborative commissioning initiatives are set out in the Collaborative Commissioning Initiatives document. The overall impact of goals and initiatives on the priority outcomes and on other related quality, health outcomes and inequalities indicators is set out in section.4.31.and the main monitoring measures for each initiative are described in section 5.4 “In-year monitoring summary.”

Outcome	G1 Improving Health and Reducing Inequalities	G2 Long Term Conditions: Prevention, Treatment, Care	G3 Care Closer to Home	G4 Maternity-Quality, Access, Choice	G5 Learning Disability, Social Care Change Programme	G6 Mental Health and Well-Being	G7 Patient Experience	Current Priority
Life expectancy at birth (years): Male	(1)			(1)		(2)		WCC
Life expectancy at birth (years): Female								WCC
Health inequalities: Average Index of Multiple Deprivation (IMD) score	(1)			(2)		(1)		WCC
Childhood obesity: Percentage of children in Year R with height and weight recorded who are obese.	(1)							VSB09 LAA
Diabetes controlled blood sugar: Percentage of patients with diabetes who have an HbA1c of 7.5 or less	(1)	(1)	(2)					VSC27 WCC
Teenage conception: Teenage conception rate per 1,000 females aged 15-17	(1)		(2)					VSB08 LAA WCC
MMR: Proportion of children aged 2 who completed immunisation for MMR (Aged 2)	(1)		(2)					VSB10 WCC
Breast cancer screening: Coverage of women aged 53-64 by PCO (less than 3 years since last test)	(2)	(1)						VSA09 WCC
Low Birth weight: Percent of live and stillbirths where babies have weighed less than 2500grams	(1)			(1)				WCC
COPD: Deaths from bronchitis, emphysema and other chronic obstructive pulmonary disease (COPD) for all ages	(1)	(1)	(2)					WCC
Self reported experience of patients and users: Patient experience score								VSB15 WCC
- Adult inpatient patient experience score (Acute Trust)								VSB15 WCC
- Adult outpatient patient experience score (Acute Trust)	(2)		(2)	(2)			(1)	VSB15 WCC
- A&E patient experience score (Acute Trust)								VSB15 WCC
- Patient experience score (Community mental health trust)								VSB15 WCC
- Patient experience score (PCT survey of primary care services)								VSB15 WCC

(1) indicates the goal has a primary impact on the outcome

(2) indicates the goal has a secondary impact on the outcome

4.3 Initiatives

This chapter provides an overview of the initiatives and the related resources. It also summarises the impact on Healthcare for London themes and priorities and the main issues in relation to collaboration, consultation, procurement and equalities impact. The detail of the initiatives is provided in appendix 5. The detail of the CCIs are covered in the separate CCI document.

Goal 1 Improving health and reducing inequalities

By 2013, we will improve health and reduce inequalities by focusing on the areas of greatest potential health gain: children & young people, and smoking and on key determinants of health improvement and inequalities.

There are clear links between lifestyle and some long-term conditions, and improving health and reducing inequalities is a theme throughout the goals

G1.1 Children and young people

This initiative has a number of components to it and is based around both redesigning existing services and commissioning new services. In reflection of the needs of children, young people and families, the detail of the initiative will be delivered in partnership with the Council's Directorate for Children, Young People and Learners, Child and Adolescent Mental Health Services, local schools and the voluntary sector to ensure the delivery of integrated, family centred, cost effective services.

The key components of this initiative are:

- Improving services for all children
- Developing targeted specialist services
- Targeting services to improve sexual health in young people

The initiative will have a primary impact on the following priority outcomes:

- Life expectancy
- Health inequalities
- MMR uptake
- Teenage conception rates.

The PCT is seeking to invest in £3.4 million in the initiative over the next 5 years.

G1.2 Smoking

In order to increase the number of smokers quitting and in order to address health inequalities we will focus our service on the more disadvantaged groups in our population, in addition to working with pregnant women and pre-operative patients, and contributing to strategies to prevent uptake of smoking amongst young people. The initiative supports the delivery of the Croydon Tobacco Control Strategy's 2008 – 2011 The main components of the initiative are about:

- Knowing where to go to
- Accessing stop smoking services
- Successful quitting

The initiative will have a primary impact on the following priority outcomes:

- life expectancy
- health inequalities
- COPD deaths.

The PCT is seeking to invest in £1.2 million in the initiative over the next 5 years.

G1.3 Healthy Weight, Healthy Lives

By helping people to achieve and maintain a healthy weight we will reduce their risk of developing a range of conditions that either reduce life expectancy or give rise to significant disability; these conditions include coronary heart disease, stroke, diabetes, and cancer. This initiative addresses requirements resulting from the Healthcare for London consultation and a key local health issue highlighted by the Healthy Croydon Partnership.

The main components of the initiative are:

- Scoping of the Obesity Strategy – Early 2009.

The revised obesity strategy and action plan will reflect the five key themes set out in the *Healthy Weight, Healthy Lives: A Cross-Government Strategy for England* published in January 2008:

- Children, healthy growth and healthy weight
- Promoting healthier food choices
- Building physical activity into our lives
- Creating incentives for better health
- Personalised advice and support

- Healthy Weight Management Service for adults
- Healthy Weight Management Service for children:

The initiative will have a primary impact on the following priority outcomes:

- Life expectancy
- Health inequalities
- Childhood obesity
- Diabetes

The PCT is seeking to invest in £1 million in the initiative over the next 5 years.

The table below shows the impact on the Healthcare for London key themes

Fit with Healthcare For London Key Themes	
Reducing health inequalities	✓
Health improvement and wellbeing	✓
Regionalisation of relevant services	
Localisation of relevant services	
Personalisation of services	
Development of integration and connected services	

CSP Healthcare for London Priorities				
Goals and Initiatives	Staying healthy	Maternity & newborn care	Children and young children	Long term conditions
Health Improvement and Reducing Inequalities				
Children and Young People	✓ Sexual health	✓	✓	
Smoking	✓ Smoking			
Healthy Weight, Healthy Lives	✓ Physical activities		✓	✓

Health improvement and inequalities cannot be tackled by one organisation. Each of the initiatives within this goal builds on the work of partnership groups and wider engagement activities. This will continue as the initiatives and the projects to deliver them are further developed. We will test the market position for delivery of many of children's outcomes and will procure the provision of 500 smoking quitters through the independent or voluntary sector during 2009/10. A scoping Equality Impact Assessment has been undertaken and a full Equality Impact Assessment will be undertaken in December 2008 for Children and Young Children. Full Equality Impact Assessments have been undertaken for the Smoking and the Healthy Weight, Healthy Lives initiatives indicating the need for social marketing and directing promotional events and activities to specific groups.

Goal 2 Long term conditions: prevention, treatment, care

By 2013 we will improve the quality of life for people with long term conditions, through designing a whole system model with generic pathways with increased self care, reduced urgent care and increased provision of planned responses.

G2.1 A whole system approach (long term conditions, disease focus, end of life)

This initiative builds on the work which began in 2005/2006 when Croydon PCT committed to lead a whole system programme to improve the organisation of care for patients with long term conditions across the local health and social care economy based on an overall framework for long-term conditions management. In addition, the initiative focuses on a service reviews and care pathway improvement in a number of specific areas, diabetes, COPD and vascular disease. Following work on the generic care pathway for long term conditions, the experience emerging from case management and the 'virtual community wards' there is a clear emphasis for the need for a more focussed approach to delivering end of life care within Croydon.

The primary components of the initiative are:

- Long term conditions
- Disease focus (Diabetes, Chronic Obstructive Pulmonary Disease, Vascular)
- End of life care
- Renal (collaborative commissioning initiative)

The initiative will have a primary impact on the following priority outcomes:

- Diabetes
- COPD deaths
- Patient experience.

The PCT is seeking to invest in £5.9 million in the initiative over the next 5 years.

G2.2 Cancers

This initiative is being scoped and developed with the Professional Executive Committee to include implementation of the national Cancer Reform Strategy. It includes the delivery of the cancer Collaborative Commissioning Initiative. It will:

- Support promotion and prevention through establishing advice, guidance and new pathways for Primary Care practitioners based on best available evidence.
- Commission advocacy and patient support services
- Invest in the expected increase in treatment numbers across a range of cancer pathways
- Implement the Liverpool Care Pathway
- Develop and implement a Gold Standard Framework for palliative care patients

The initiative will have a primary impact on the following priority outcomes:

- Life expectancy
- Health inequalities
- Breast cancer screening.

The PCT is seeking to invest in £3.3 million in the initiative over the next 5 years.

The table below shows the impact on the Healthcare for London key themes

Fit with Healthcare For London Key Themes	
Reducing health inequalities	✓
Health improvement and wellbeing	✓
Regionalisation of relevant services	
Localisation of relevant services	✓
Personalisation of services	✓
Development of integration and connected services	✓

CSP Healthcare for London Priorities				
Goals and Initiatives	Staying healthy	Long term conditions	End of life care	Settings of care
Long Term Conditions				
LTC (including disease specific focus and End of Life)	✓ Vascular prevention ✓ Diabetes Strategy	✓	✓ End of Life	✓
Cancer	✓ Screening			

These initiatives build on the work of partnership groups and wider engagement activities. This will continue as the initiatives and the projects to deliver them are further developed. Plans for expanding the long term conditions whole system approach will be considered by the Scrutiny Committee and new services and new contracts will be awarded following formal tender and procurement processes. A national cancer Equalities Impact Assessment has been undertaken which indicates an number of issues which the PCT will take forward locally. For example the health inequalities impact assessment and local outcome data demonstrate very low take up of breast cancer screening in BME communities and specific consultation/engagement will be integral to the improving access to services and so individual plans for consultation will be worked up for each of the service/disease redesign projects. A full local Equality Impact Assessment for cancers will be undertaken in December 2008.

Goal 3 Case closer to home

By 2013 we will have models of care and deliver services designed around the needs and preferences of local people, which provide services closer to home where possible and centralised where necessary, based on quality and expertise.

G3.1 Planned care

This initiative provides a systematic approach to reviewing existing care pathways and delivering new ones in order to improve quality of care and access to services and to secure better value. Models of care will be based on current evidence, clinical guidance, quality standards and good practice in clinical service areas, including referral management and improvements to patient experience. The main components are:

- Review and redesign of a prioritised set of clinical pathways
- Scope the impact of redesigned services on diagnostic, primary and community based services
- Paediatrics (Collaborative Commissioning Initiative)

The initiative will have a primary impact on the following priority outcomes:

- Patient experience.

The PCT is seeking to invest in £5.2 million in the initiative over the next 5 years.

G3.2 Urgent care

This initiative reviews the availability, quality and proximity of Urgent Care provision to the population of Croydon, to ensure that urgent care services are designed around the needs and preferences of local people, which provide services closer to home where possible. This will facilitate the direct targeting of inequalities in urgent care access and enable prioritisation of services to particular community demands.

The main components of the initiative are:

- Revision of patient pathways to include best practice and full compliance with all relevant guidance
- Develop implement the urgent care strategy, revising patient pathways
- Stroke (Collaborative Commissioning Initiative)
- Major Trauma (Collaborative Commissioning Initiative)

The initiative will have a primary impact on the following priority outcomes:

- Patient experience.

The PCT is seeking to invest in £4.8 million in the initiative over the next 5 years.

G3.3 GP Led Health Centre and Primary Care Networks

The Primary and Community Services Strategy sets out the PCT's plan for a network of health centre developments. It will support the 5% year on year shift of secondary care activity into primary and community care. In each of the 6 clusters a hub is proposed. These hubs will be established over the time of the CSP and support the redesign of urgent care and services closer to home. An urgent care front end service for Mayday will be subject to formal consultation in early 2009. Parkway Health Centre, Purley hospital redevelopment and central Croydon's GP Led Health Centre are existing agreed developments and are reflected in our Primary and Community Services and Urgent Care Strategy.

The initiative will have a primary impact on the following priority outcomes:

- Patient experience

The PCT is seeking to invest in £6.7 million in the initiative over the next 5 years.

Together the three initiatives within this goal enable the delivery of services closer to home where possible and centralised where necessary and are underpinned by three key strategies:

- The Primary and Community Service Strategy, which supports the wider health improvement initiatives.
- The Urgent Care Strategy, which supports the move towards the provision of urgent care services closer to home
- The move towards commissioning evidence based, high quality health services and consistency of access to patients to elective services. The South West London Effective Commissioning Initiative (SWL ECI) provides a set of patient criteria to inform the commissioning of surgical interventions across the sector.

The table below shows the impact on the Healthcare for London key themes

Fit with Healthcare For London Key Themes	
Reducing health inequalities	
Health improvement and wellbeing	
Regionalisation of relevant services	✓
Localisation of relevant services	✓
Personalisation of services	✓
Development of integration and connected services	✓

CSP		Healthcare for London Priorities		
Goals and Initiatives	Staying healthy	Acute care	Planned care	Settings of care
Care Closer to Home				
Planned Care	✓ Prevention and promotion built into pathways	✓	✓	✓
Urgent Care		✓ ✓ Stroke ✓ Trauma		✓
GP Led health Centre and Primary Care Networks	✓ Wider range professionals		✓	✓

The PCT is working together with partner organisations to provide integrated health and social care. The PCT will continue to work in collaboration with the Local Authority, PBC groups, Local Medical Committee (LMC), Local Optical LOC, LPC, individual clinicians, patient groups and with Mayday hospital in the development of these initiatives. Consultation is already planned for early 2009 for the key strategies, with individual plans for consultation worked up for each of the service redesign projects as necessary. The PCT is working across the sector on Paediatrics, Stroke and Trauma as described in the CCI and is closely linked to the Healthcare for London priorities. The local health economy will be managed to avoid the destabilisation of secondary care. A cycle of review of services and retendering of services will be carried out to ensure that the market is managed to best effect on an ongoing basis. Scoping Equalities Impact Assessments have been undertaken for each of the pathway redesign areas and indicates the full assessment is not required. A full Equalities Impact Assessment will be undertaken for Urgent Care in December 2008. A full Equalities Impact assessment has been carried out on the GP led Health Centre and it is clear that the location and nature of the services that will be offered will offer better access and location to meet the diverse needs of the Central Croydon population.

Goal 4 Maternity: Quality, Access, Choice

By 2013 we will improve the quality and infrastructure of maternity services and ensure that all women have choice about the maternity care they receive, together with improved access to services and continuity of midwifery care and support.

G4.1 Promoting birth as a normal event

This initiative will facilitate normal childbirth wherever possible, with medical interventions recommended only when they are of benefit to the woman and/or her baby. Low risk women may choose to have midwifery-led care, including a home birth, and Standard 11 of the Children, Young Peoples and Maternity Services National Service Framework promotes an environment that replicates a home-like ambience. The primary components of the initiative are:

- Increased number of women accessing a midwife as first point of contact
 - Increased percentage of women who have seen a midwife or a healthcare professional for health and social care assessment of needs and risk by 12 weeks of their pregnancy
 - Promotion of choice of birth/homebirths
 - Increased number of women accessing birth centre
 - Reduced use of pharmacological methods of pain relief
 - Further reduce the rate of caesarean births
- Maternity (Collaborative Commissioning Initiative)

The initiative will have a primary impact on the following ten health outcomes:

- Life expectancy
- Health inequalities
- Low birth weight.

G4.2 Provision of high quality, safe and accessible maternity service that are both women focused and family centred

This initiative will ensure that women have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies. Improving equity of access to maternity services will contribute to an increase the survival rates and life chances of children from disadvantaged backgrounds. The primary components of the initiative are:

- Increased percentage of women receive one to one care during established labour
 - Increased rate of mothers breastfeeding, and the implementation of the 'Baby Friendly Initiative'
 - Promotion of positive infant and maternal mental health and training of frontline staff
 - Improved experience of mothers
- Neonatal Intensive Care (Collaborative Commissioning Initiative)

The initiative will have a primary impact on the following priority outcomes:

- Life expectancy
- Health inequalities
- Low birth weight
- Patient experience.

The PCT is seeking to invest in £2.3 million in the two initiatives over the next 5 years.

The table below shows the impact on the Healthcare for London key themes

Fit with Healthcare For London Key Themes	
Reducing health inequalities	✓
Health improvement and wellbeing	
Regionalisation of relevant services	✓
Localisation of relevant services	✓
Personalisation of services	✓
Development of integration and connected services	✓

CSP Healthcare for London Priorities			
Goals and Initiatives	Maternity & newborn care	Children and young children	Mental health
Maternity			
Quality of services			
Birth as a normal event	✓	✓	✓

The development of this initiative will be driven by the Maternity Services Liaison Committee (MSLC). The PCT is working in collaboration across the sector to deliver the CCIs for maternity, neonatal Paediatrics. There is no plan for procurement of new maternity services for 2008/09. Croydon PCT will adopt the PCT procurement policy and the national procurement guidelines, should procurement be required. Fostering good working relationship between acute providers and the PCT provider services will continue. A full Equalities Impact Assessment has been undertaken with a key action being to improve the quality of information.

Goal 5 Learning Disabilities : Social Care Change Programme

By 2013 we will improve services and promote independence for people with learning disabilities through the delivery of the social care change programme which will reprovide services for clients currently in community homes.

G5.1 Social Care Change Programme

This initiative has been created to manage the transfer of current resources invested in Surrey and Borders Partnership NHS Trust to independent not for profit, voluntary and private sector providers for the provision of residential care and group home living. The aim is to enhance choice and independence for adults with learning disabilities who are former NHS hospital patients. The Learning Disability services are social care services and outcomes do not fall into a traditional model of outcomes for monitored medical conditions. However, an outcome for all clients should be that they will have person centred plans and health action plans implemented and their assessed needs will be met. Close monitoring with Commissioning and Care Management input is needed to ensure that outcomes are prioritised in line with the PCT strategic goals.

There are 121 Croydon residents subject to this change programme currently living in NHS managed homes, the majority in 22 Croydon based homes. The Social Care Change Programme is being implemented in a phased approach which commenced in January 2007 and will conclude in 2010. This is being managed in two main groupings: Homes that will transfer in their current state and homes for development. Croydon has 11 homes in each category. This twin approach allows the earliest possible transfer to be achieved. A person centred solution will be sought for all people living in any of the homes regardless of which group their home is in.

The initiative will have a primary impact on the following priority outcomes:

- Patient experience.

The table below shows how the goal supports delivery of the Healthcare for London key themes.

Fit with Healthcare For London Key Themes	
Reducing health inequalities	
Health improvement and wellbeing	
Regionalisation of relevant services	
Localisation of relevant services	✓
Personalisation of services	✓
Development of integration and connected services	

CSP		Healthcare for London Priorities	
Goals and Initiatives		Settings of care	
Learning Disabilities			
Social Care Change Programme		✓	

Each home or, where appropriate, group of homes, is being managed as a separate project which focuses on individual plans for each service user and which directly engages people who use the service, relatives and other stakeholders in developing plans for the future. The procurement process will identify and select “preferred providers”. Formal tendering will commence as each project management group defines its preferred solution. The project will find solutions that are flexible and capable of change or discontinuation once the current population no longer requires the service.

Goal 6 Mental health and well being

By 2013 we will improve the mental health and well being of the local population, by ensuring services are organised and delivered to better meet people’s needs, especially those of vulnerable groups, and by working with other partners to promote mental wellbeing in the community at large.

Croydon PCT will ensure initiatives to promote mental health and well-being of the local population, and effective mental health services for the local population. Croydon’s third mental health promotion strategy (2009-2012) is currently being developed, with the aim of improving mental health and well-being in the local population. Over the next five years Croydon Primary Care Trust aims to develop mental health services to better meet the needs of the local population, both existing needs, and anticipated needs.

- G6.1 Delivery and implementation of Croydon Mental Health Promotion Strategy
 - Safer and stronger communities
 - Healthier communities and older people
 - Children and young people
 - Economic development and enterprise

The PCT is seeking to invest in £300,000 million in the initiative over the next five years

- G6.2 Improving mental health services
 - Psychological Therapies
 - Mental Health of Older Adults (Dementia Care)
 - Early Intervention in Psychosis services
 - Social Inclusion
 - Mental Health (Collaborative Commissioning Initiative)

The initiative will have a primary impact on the following priority outcomes:

- Health inequalities
- Patient experience.

The PCT is seeking to invest in £3.4 million in the initiative over the next 5 years.

The table below shows the impact on the Healthcare for London key themes

Fit with Healthcare For London Key Themes	
Reducing health inequalities	✓
Health improvement and wellbeing	✓
Regionalisation of relevant services	
Localisation of relevant services	✓
Personalisation of services	✓
Development of integration and connected services	✓

CSP			Healthcare for London Priorities	
Goals and Initiatives		Staying healthy	Mental health	
Mental Health				
Health and well being		✓Mental and emotional well being	✓	
Improved services				

The Mental Health Promotion Strategy Steering Group will have the remit of overseeing the development and delivery of the local Mental Health Promotion Strategy and Action Plan. The steering group membership includes PCT, council, voluntary services and service users.

The Psychological Therapies service anticipates new resource, including a bid to the IAPT Pathfinder Programme. The assumption is that new services will be tendered on the open market. A number of local providers, particularly from the voluntary and community sector, have already expressed an interest. The service development strategy for intermediate care will likely see opportunity for new providers to enter the local Mental Health of Older Adults (Dementia Care) health economy, particularly from the voluntary and community sector, which is absent at present. The plan therefore would be to tender for any new services that are required. Commissioners anticipate tendering for new services realised through the Social Inclusion project.

Full Equalities Impact Assessment will be undertaken in December 2008.

Goal 7 Patient Experience

By 2013, we will improve peoples' experience of health and healthcare through systematic use of feedback, patient experience data, and engagement throughout the commissioning cycle.

G7.1 Patient Centred Improvement

- Targeted improvements to patient experience in response to performance monitoring reports and feedback
- Using patient experience information to design, influence and improve services
- Developing systematic assurance processes for ensuring improvements in patient experience outcomes including service specifications and metrics to demonstrate impact of initiatives

The delivery of this initiative is supported by one of the Organisational Development Plan goals, to systematically use information to support decision making and delivery

The initiative will have a primary impact on the following priority outcomes:

- Patient experience.

The PCT is seeking to invest in £400,000 in the initiative over the next 5 years.

The table below shows the impact on the Healthcare for London key themes

Fit with Healthcare For London Key Themes	
Reducing health inequalities	
Health improvement and wellbeing	
Regionalisation of relevant services	
Localisation of relevant services	
Personalisation of services	✓
Development of integration and connected services	

Whilst there is no expectation to for formal consultation, this initiative will require the PCT to work with all local providers and develop a coherent partnership approach to improvement work. There will be strands of work which will require procurement of external consultancy services, specifically around securing community involvement to promote access to primary care. A full Equalities Impact Assessment will be undertaken in December 2008.

4.3 Overall impact

The overall impact of the goals aims to ensure we add 'life to years and years to life', whilst also ensuring the quality of services are driven up and patient's expectations are met.

4.3.1 Overall impact on quality, health outcomes and inequalities

Quality

The reconfiguration of care pathways and service delivery in order that healthcare is delivered closer to home where possible and centralised where necessary will result in quality improvements. Patient safety and the quality of care received will be driven up through delivering care in the clinically most appropriate settings and through ensuring an evidence-based, equitable and geographically-appropriate approach to commissioning and service delivery. Efficiency improvements in healthcare delivery will also positively impact upon patient satisfaction, and on quality of life in addition to quality of healthcare. The end of life care initiative will also improve quality of death.

Many of the initiatives have a particular focus on improving quality from the perspective of the patient experience.

The delivery of the initiatives will contribute to meeting the quality indicators, standards, recommendations and requirements as set out in: the National Service Frameworks for CHD, Diabetes, Older People, Long Term Conditions, Renal Services, Children, and the awaited National Service Framework for COPD; the Healthcare Commission Service Reviews; NICE Guidance; and government White and Green Papers including Choosing Health, Maternity Matters, Care Matters, Valuing People, Commissioning for Health & Well-being, and Our Health, Our Care, Our Say. The initiatives will also assist the PCT in maintaining compliance with Healthcare Commission core standards, and in making progress against the developmental standards.

Health outcomes

The initiatives deliver many of the health outcome targets that have represented a particular challenge to the PCT in recent years, including smoking cessation, teenage pregnancy and obesity. This includes the ten priority measures as outlined in section 4.1 which were selected based on the needs and aspirations of our population, local strategic priorities and benchmarking of current performance.

In the future the PCT intends to undertake comprehensive analyses of health needs using models that incorporate the interactions of co-morbidities on future health need and has prioritised predictive modelling and economic evaluation in its organisational development plan.

The first table below shows how the goals and initiatives will impact on the ten priority outcomes with indicative trajectories. The second table summaries the overall impact of the goals on related quality, outcomes and inequalities indicators.

Outcome	Primary Initiative To Impact Outcome	Secondary Initiative To Impact Outcome	Baseline year and data	National baseline year and data	2008/09	2009/10	2010/11	2011/12	2012/13	Current Priority
Life expectancy at birth (years): Male	G1.2 Smoking G1.3 HWM	G.1 C&YP G6.1 Mental health and wellbeing	78.3 (2005-07)	77.7 (2005-07)	79.5	79.8	80.2	80.5	80.9	WCC
Life expectancy at birth (years): Female	G4.1 Birth as a normal event		82.0 (2005-07)	81.8 (2005-07)	82.1	82.2	82.3	82.4	82.5	WCC
Health inequalities: Average Index of Multiple Deprivation (IMD) score	G.1 C&YP G1.2 Smoking G1.3 HWM G6.1 Mental health and	G2.3 Cancers G4.1 Birth as a normal event	21.31 (2007)	23.73 (2007)	Guidance required for trajectory setting					WCC
Childhood obesity: Percentage of children in Year R with height and weight recorded who are obese.	G1.3 HWM	G1.1 C&YP	12.0% (2006-07)	9.9% (2006-07)	13.0%	13.3%	13.6%	13.9%	14.2%	VSB09 LAA
Diabetes controlled blood sugar: Percentage of patients with diabetes who have an HbA1c of 7.5 or less	G1.3 HWM G2.1 LTC	G3.3 GP Led Health Centre and Primary Care Networks	53.9% (Mar 2008)	60.1% (Mar 2008)	56%	58%	60%	62%	64%	VSC27 WCC
Teenage conception: Teenage conception rate per 1,000 females aged 15-17	G.1 C&YP	G3.3 GP Led Health Centre and Primary Care Networks	56.9 (2006)	40.6 (2006)	41.4	38.5	38.3	38.1	29.9	VSB08 LAA WCC
MMR: Proportion of children aged 2 who completed immunisation for MMR (Aged 2)	G.1 C&YP	G3.3 GP Led Health Centre and Primary Care Networks	77.3% (2007/8)	84.6% (2007/8)	80%	85%	90%	92.5%	95%	VSB10 WCC
Breast cancer screening: Coverage of women aged 53-64 by PCO (less than 3 years since last test)	G2.3 Cancers	G1.2 Smoking G1.3 HWM	70.6% (Mar 2007)	76.0% (Mar 2007)	71.7%	72.8%	73.8%	74.9%	76.0%	VSA09 WCC
Low Birth weight: Percent of live and stillbirths where babies have weighed less than 2500grams	G1.2 Smoking G4.1 Birth as a normal event	G1.1 C&YP	8.9% (2006)	7.9% (2006)	8.7	8.5	8.4	8.2	8.0	WCC
COPD: Deaths from bronchitis, emphysema and other chronic obstructive pulmonary disease (COPD) for all ages	G1.2 Smoking G2.3 LTC	G3.3 GP Led Health Centre and Primary Care Networks	30.6 (2004-06)	27.0 (2004-06)	28.9	27.2	25.5	23.8	22.1	WCC
Self reported experience of patients and users: Patient experience score	G7.1 Patient Centred Improvement	G3.2 Urgent Care G3.3 GP Led Health Centre and Primary Care Networks G4.2 Maternity quality								VSB15 WCC
- Adult inpatient patient experience score (Acute Trust)			69.5 (2005/6)	Data supplied only by Trust	69.5	70.0	70.5	71.0	71.5	VSB15 WCC
- Adult outpatient patient experience score (Acute Trust)			72.5 (2004/5)		72.5	73.0	73.5	74.0	74.5	VSB15 WCC
- A&E patient experience score (Acute Trust)			73.3 (2004/5)		73.3	73.8	74.3	74.8	75.3	VSB15 WCC
- Patient experience score (Community mental health trust)			73.4 (2005/6)		73.4	73.9	74.4	74.9	75.4	VSB15 WCC
- Patient experience score (PCT survey of primary care services)			75.1 (2004/5)		75.1	76.0	77.0	78.0	79.0	VSB15 WCC

Outcomes shaded yellow are Operating Plan trajectories.

	G1 Improving Health and Reducing Inequalities	G2 Long Term Conditions: Prevention, Treatment, Care	G3 Care Closer to Home	G4 Maternity	G Learning Disability: Social Care Change Programme	G 6.1 Mental Health and Well-Being	G 7.1 Patient Experience
HEALTH OUTCOME AND INEQUALITIES IMPACT							
Life expectancy at birth	✓	✓		✓		✓	
Health inequalities	✓	✓		✓		✓	
Infant Mortality Rate	✓			✓			
Low birth weight	✓			✓			
Breastfeeding	✓			✓			
Immunisation	✓		✓				
Caesaren rate				✓			
Obesity	✓						
Teenage conception	✓		✓				
Chlamydia prevalence	✓		✓				
Smoking quitters	✓						
Healthy Schools	✓						
Diabetes controlled blood sugar (HbA1c)		✓	✓				
Cancer screening		✓					
Cancer prevalence	✓	✓					
Diabetes: prevalence	✓	✓	✓				
Diabetes deaths		✓	✓				
COPD: Deaths	✓	✓	✓				
COPD :Prevalence	✓	✓	✓				
CVD :prevalence	✓	✓	✓				
CVD deaths	✓	✓	✓				
QUALITY IMPACT							
Patient experience		✓	✓	✓	✓		✓
Access to primary care			✓			✓	
Waiting times treatment		✓	✓			✓	
Delayed transfer of care		✓					
SHIFT IN ACTIVITY							
Shift in secondary to primary care activity			✓				
A&E attendances			✓				

Outcomes which are bold relate to the ten priority outcomes

Reducing health inequalities

Smoking is the greatest identifiable contributor to inequalities in health and life expectancy, with those living in deprived areas more likely to smoke. The smoking initiative will target people living in disadvantaged areas, pregnant women, pre-operative patients and the ethnic groups with the highest prevalence. This will have a major impact on reducing health inequalities over the longer term. Health inequalities cannot be tackled at an individual service level. The children & young people

initiative, in particular, highlights the importance of joined up action. This initiative also undertakes targeted work with one of the most vulnerable groups of the population (looked after children and young people), which will contribute to wider actions to break the generational cycle of poor health – work to tackle from pre-conception and in early life. The maternity initiative also seeks to provide enhanced support for the most vulnerable mothers and babies, aiming to maximise their potential, which would ultimately lead to a reduction in inequalities. The infant mortality rate is a key component of the national health inequalities target. This will be addressed through the combined effects of actions within two different initiatives G1.1 Children and Young People and G4.1 Maternity. A reduction in inequalities in access to healthcare should be a consequence of efficiency improvements and service delivery reconfigurations.

Equality impact screening assessments have been completed for all initiatives and full impact assessments have been undertaken or are scheduled if required. The key themes arising are the need to:

- Improve data quality particularly for disability, race, religion and sexuality. This is a key organisational development priority to systematically use information, including involvement and experience data, to support decision making and delivery
- Engage social marketing to better co-ordinate effective campaigns. This is a key communications strategy priority area and the PCT will develop its knowledge and use of marketing both internally and externally.
- Ensure we engage seldom heard groups and target events accordingly. This is a key patient and public involvement strategy priority area which aims to remove the barriers to engagement for people from 'seldom heard' groups and find ways to routinely hear the voices of local people from all parts of society.

4.3.2 Overall impact on activity

This plan indicates the growth in total activity required due to population growth (1.0 to 1.1% per annum); prevalence which is specialty specific (0.5% to 1.2% per annum) plus significant growth in stroke, cardiac, renal and specialised commissioning; full year effects of 2008/09 activity and developments as detailed in the finance and activity template. The table below indicates the effects of the above over the period 2008/09 to 2012/13, with more detail in the finance and activity template.

Activity	2008/09 Forecast	2009/10 Plan	2010/11 Plan	2011/12 Plan	2012/13 Plan
Elective inpatient and day case spells	35,491	35,787	36,175	36,546	36,923
Non elective and emergency spells	34,623	35,078	35,548	36,047	36,563
Outpatient attendances	314,047	311,519	309,085	306,995	304,991
A and E attendances	123,041	116,614	108,840	99,997	89,997
Ambulance journeys	32,226	32,548	32,874	33,023	33,535
Walk-In-Centre attendances	29,809	30,107	30,408	30,712	31,020
Dental UDAs	490,126	508,228	513,310	518,443	523,628

This plan will lead to increasing activity within community and primary care settings, mostly the re-provision of hospital outpatient services and the opening of planned and urgent care centres across Croydon. This will lead to an overall reduction of care within the secondary care settings as demonstrated in the table below.

Impact on Activity	2008/09	2009/10	2010/11	2011/12	2012/13
Outpatients	-12,461	-18,903	-32,715	-48,939	-62,801
Non-elective spells	-568	-470	-734	-360	-581
Elective spells		95	313	405	404
Other (eg, ward attenders etc.)	12,155	31,552	22,075	8,969	4,661
Total A&E Attendances		-4,939	-27,171	-42,795	-59,912
Direct Access	5,976	2,164	393	799	750
Other Non-HRG (eg, high cost drugs)			20	40	40
Total Walk in Centres Attendances		4,939	27,171	42,795	59,912
Total GP Practice appointments available	4,340	8,774	26,280	50,896	62,230

Note that the growth in GP appointments, mostly outpatient activity transferred from secondary care, is an estimate and will be dependent on the tendering of demand management, service redesign and other plan schemes supporting the PCT's strategic goals, GPs may not always be awarded the contracts.

The increase of more specialised centres for stroke and major trauma will lead to increases within tertiary care.

4.3.3 Overall impact on finance

The summary financial position for the PCT is as follows:

	2008/09 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000
Income	491,207	527,469	551,009	569,045	590,914
Expenditure	485,207	520,028	546,417	564,271	585,948
Surplus/ (Deficit)	6,000	7,441	4,592	4,774	4,966

More detail is provided in the finance and activity templates.

The PCT's financial plans are based on the NHS London planning assumptions as follows:

Planning Assumptions	2008/09	2009/10	2010/11	2011/12	2012/13
PCT Uplift	5.5%	5.8%	5.8%	4.0%	4.0%
Top Slice	No new top slices				
Pan London Investment Fund		1%	1%		
Scenarios		+ or - 1%	+ or - 1%		
Carry Forward	Surpluses carried forward each year				
Contingency	In Outturn	Maximum of 0.5% each year			
Surpluses	Reduced to 0.8% over the period				
Demographic growth	As per GLA				
Prevalence rates	Based on national and local data				
Tariff uplift	2.30%	2.80%	2.80%	1.00%	1.00%
Pay awards	2.75%	2.40%	2.25%	2.25%	2.25%
Prescribing uplift	8.00%	8.00%	8.00%	8.00%	8.00%
Primary care contracts	1.50%	1.50%	1.50%	1.50%	1.50%

Subsequent to the issuing of the above assumptions to London PCTs, discussions have taken place across London concerning an NHS London Medium Term Financial Strategy (MTFS), requiring PCTs to contribute 1.3% rather than 1% to a pan London investment fund and this has been allowed for. NHS London's MTFS also requires investment to support the transition costs for Healthcare for London to be managed on a sector basis, Croydon is part of the SW London sector, and Croydon PCT transition costs have been included in these assumptions.

As far as local assumptions are concerned, the PCT's plans take into account the full year effects of 2008/09 estimated outturn for commissioning costs, demand management schemes and current operating plan developments. These financial plans include the financial impacts of the Commissioning Strategy Plan. Over the period 2008/09 to 2011/12 the PCT will have invested £38 million in new services with £13 million funded from disinvestments, mostly acute care, and £25 million from growth monies.

Goal / Initiative	2008/9 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000
G 1.1 Children and young people	1,705	498	984	181	26
G 1.2 Smoking cessation	490	380	100	100	100
G 1.3 Healthy weight healthy lives	380	225	275	75	
G 2.1 Long term conditions	1,458	781	924	1,492	1,213
G 2.2 Cancers	517	653	316	899	897
G 3.1 Planned care	2,389	529	120	1,110	1,045
G 3.2 Urgent care	1,475	362	906	906	1,127
G 3.3 GP led health centre/ primary care	442	500	1,622	2,468	1,638
G 4.1 Maternity	709	603	207	775	505
G 5.1 Learning disability: social care					
G 6.1 Mental health and wellbeing			115	100	100
G 6.2 Mental health services	420	1,032	877	642	403
G 7.1 Patient-centred improvement	50	75	225	75	
Total	10,035	5,637	6,670	8,822	7,054

The PCT has modelled the impact of + 1% and – 1% changes in growth, allocation, assumptions and the actions to address these scenarios. In summary a 1% increase

in growth would see the PCT advancing its investments to earlier years and/or there would be some non recurrent investments in areas such as primary and community care strategies. A 1% decrease in growth would see a reduction in monies available for growth and/or a reduction in surplus and/or an increase in savings requirements from demand management and cash releasing efficiency savings.

The PCT has modelled the risks and opportunities underpinning this plan under the following scenarios:

Risks:

- Overperformance of acute contracts
- Increase in forensic activity
- Reduction in growth funding
- Slippage of demand management schemes
- Increase in prescribing volumes/ NICE approvals/DoH policy decisions

Proposals to mitigate against these pressures include slipping developments, increasing demand management schemes and/or cash releasing efficiency savings, increasing programme and project management resources, and as a last resort service cuts.

Opportunities:

- Increase in growth funding
- Demand management savings greater than anticipated
- Healthcare for London savings faster than anticipated
- Reduction in acute elective activity after achievement of 18 week targets
- Greater deflation in prices arising from a recession

Proposals to take advantage of these opportunities mostly involve advancing service developments, recurrently and non recurrently.

Last, but not least, the marginal financial analysis impact on the PCT’s programme budgeting analysis has major impacts on:

Programme budget category	£'000
2 Cancers and tumours	5,519
5 Mental health problems	3,281
18 Maternity and reproductive health	2,798
21 Healthy individuals	3,685
TOTAL	15,283

These figures are real terms increases and exclude general demographic and prevalence growth. Investments in planned care, urgent care, long term conditions and GP led health centres under current programme budgeting definitions are not possible to identify to individual programme budget categories. However the PCT has addressed in real terms those areas where there is an underinvestment issue as part of this Commissioning Strategy Plan as demonstrated above and the long term conditions work stream addresses a number of disease categories where funding is below the PCT cluster average.

4.3.4 Overall impact on Healthcare for London implementation

In reviewing the CSP the PCT has aligned local priorities with results of the Healthcare for London consultation and implementation of the London vision and framework. The key themes which underpins the Healthcare for London framework and therefore the CSP are:

- Reducing health inequalities
- Health improvement and wellbeing
- Regionalisation of relevant services
- Localisation of relevant services
- Personalisation of services
- Development of integration and connected services

Healthcare for London also identified a number of specific projects and priorities, some of which have already had project teams established for a number of months.

- Staying healthy
- Maternity & newborn care
- Children and young children
- Mental health
- Acute care
- Planned care
- Long term conditions
- End of life care
- Settings of care

Achievement of agreed aims in these projects and priorities is therefore a key aspect of the PCTs strategy, and implementation is being taken forward across the goals in the CSP and in the CCLs.

The table below summarises the overall delivery of the healthcare for London themes by goal.

CSP Goals	Fit with Healthcare For London Key Themes					
	Reducing health inequalities	Health improvement and wellbeing	Regionalisation of relevant services	Localisation of relevant services	Personalisation of services	Integrated and connected services
Health Improvement	✓	✓				
Long term Conditions		✓			✓	✓
Care Closer to home			✓	✓	✓	✓
Maternity	✓		✓	✓	✓	✓
Learning Disabilities				✓	✓	
Mental Health		✓		✓	✓	✓
Patient Experience					✓	

The goals and initiatives will support delivery of the Healthcare for London priorities locally:

- Goal 1 – Improving health and reducing health inequalities will support delivery of the sexual health, the smoking cessation, the physical activities, the maternity, and the children and young people priorities

- Goal 2 - Long term conditions: Prevention, treatment, care will support delivery of the long term conditions, the vascular prevention, the diabetes strategy, the end of life care, the screening and the settings of care priorities
- Goal 3 – Care Closer to Home will support delivery of the acute care, the planned care, the settings of care and the prevention and promotion built into pathways priorities
- Goal 4 –Maternity: Quality, Access, Choice will support delivery of the Children and Young People, the Maternity and newborn care and the Mental Health priorities
- Goal 5 – Learning Disability: Social Care Change Programme will support delivery of the settings of care priority
- Goal 6 – Mental health and Well-Being will support delivery of Mental health and emotional well-being and mental health services priorities
- Goal 7 – Patient experience will support delivery of the maternity priority

4.3.5 Overall impact on consultation

There are a number of public consultations expected in implementing Healthcare for London (HfL), the South West London Collaborative Commissioning Initiatives (SWL CCI) and this Commissioning Strategy Plan (CSP) these are outlined below:

Consultation Priorities		Date
Goal 1: Improving health and reducing inequalities		
Children and Young people HfL CSP	HfL aims to follow from NHS London Development of Child Health Promotion Programme	To Follow from NHS London 2009
Healthy Weight, Healthy Lives CSP	Strategy being developed	Early 2009
Goal 2: Long Term Conditions: Prevention, Treatment, Care		
Diabetes HfL	Basic care pathways set out for local adaption within individual PCTs. More specialised care pathway defined for the more challenging aspects of care such as diabetes in those with significant mental illness. Access to specialist services only for those with clinical need.	To Be Confirmed
Renal SWL CCI	Better prevention, earlier diagnosis and optimum treatment of patients with CKD: Ensure In-patient services are of very best quality and delivered cost-effectively Promote choice of treatment modality as close to peoples homes as far as possible but centralise when necessary	To Be Confirmed
Cancer SWL CCI	Implement clinically effective care pathways Ensure cancer services are commissioned in line with pathways and provided in the most appropriate setting	To Be Confirmed

Goal 3: Care Closer to Home		
Primary and Community Services Strategy CSP	A framework about how primary and community services can work better together as a network Six network hubs including a GP Led Health Centre	January – March 2009
Urgent Care Strategy CSP	A framework for better primary urgent care response	January - March 2009
Polyclinics HfL	Polyclinics to offer a far greater range of services than currently offered in GP practices, whilst being more accessible and less medicalised than hospitals.	See Primary and Community Services Strategy
Unscheduled Care HfL	Establish a tiered approach which delivers prompt, consistent responses to patients assessed needs within a whole system	See Urgent Care Strategy
Stroke HfL SWL CCI	Introduce prevention and awareness programmes Establish a designated stroke centre for SWL population Implement the community rehabilitation standards for stroke services in line with HfL	January – March 2009
Major Trauma HfL SWL CCI	Implement an inclusive trauma system Introduce new service models serving SWL population to include the designation of Major Trauma Centres (MTC)	January – March 2009
Goal 4 Maternity: Quality, Access, Choice		
Maternity SWL CCI	Reduce variability in quality of antenatal and post natal care; Review capacity and demand taking into consideration revised care pathways and service models to ensure capacity Develop a mixed economy of provision in SWL as most births occur in a hospital setting	To Be Confirmed
Neonatal SWL CCI	Provide high quality and skilled neonatal care in the most appropriate setting Minimise number of inappropriate transfer for mothers and babies Ensure equal access to the specialised centre for very sick babies Assure capacity and skills to support treatment of all babies in a unit which is appropriate to their needs	To Be Confirmed
Paediatrics SWL CCI	Identify sector wide priorities Develop integrated and shared care pathways Provide sustainable inpatient paediatric provision across SWL and rationalise onto fewer sites	To Be Confirmed
Goal 6 Mental Health and Well-Being		
Mental Health SWL CCI	Produce a revised mental health needs assessment with borough focus Develop and consult on proposal for future commissioning of the three key MH services Implement new service model/proposal	To Be Confirmed

The PCT is working to ensure our commissioning decisions reflect the needs and priorities and aspirations of Croydon. The PCT has been using its engagement and consultation activities to ensure the work that the PCT does is shaped by a range of people. The PCT is also working to strengthen its methods of engaging and consulting to ensure it underpins all that it does, through the Communications Strategy and the Patient and Public Involvement Strategy.

Formal consultation will follow the London guide to reconfiguration and will be undertaken in liaison with the Local Overview and Scrutiny Committee. Engagement and consultation will follow the multi agency Croydon Community Involvement Commitments and be publicised on Talk2 Croydon website

4.3.6 Overall impact on the provider landscape

The Commissioning Strategy Plan will enable a significant shift in where people receive their health care. There will be a shift from the traditional development of service delivery in hospital settings and more emphasis on health care being geographically closer to home where possible and centralised where necessary based on quality, safety and value for money.

Primary care

The biggest impact of the Commissioning Strategy Plan will be on GPs, with some impact on community pharmacists. It will have relatively little impact on dentists and opticians.

Overall there will be an overall increase in the number of people seen by GP, however the case mix of patients will be very different. As people learn to manage their illnesses better those with chronic disease will have fewer visits to the GP. However the redesign of pathways will see an increase in specific specialties. Pharmacists will have a role to play in supporting the pathways, but their biggest role will be supporting the health improvement agenda.

The primary care strategy and the estates strategy will support this shift to allow for the new needs to be met effectively.

Community and intermediate care

The impact for community and intermediate care will also be an increase in the number of patients being cared for in the community. This will require a change in the way in which services are delivered and require even closer working with secondary and primary care. There will need to be an increase in capacity in some services, to meet the requirements of redesigned pathways and patient choice.

Secondary care

Over the next 5 years, Mayday will have a reduction in the number of emergency admissions as people with chronic diseases learn to take care of their conditions better and as the virtual wards expand to cover the whole of Croydon.

Mayday will be able to focus on healthcare that needs to be delivered within a hospital setting. There will be significant impact on specific specialties as pathways are redesigned which will result in a reduction in outpatients and on maternity services as there will be an increase in home births and the number of birthing

centre births. Whilst the new model for delivering urgent care is to be consulted in early 2009 there will be a reduction in attendances at A&E.

Whilst there will be some minor impact on our other secondary care elective providers the level of materiality is small when compared to environmental volatility and the effects of Choose and Book and patient choice. As such we will address any impact on other secondary care providers within service level agreements negotiation, but do not believe they will have any material impact on the Commissioning Strategy Plan assumptions.

Independent Sector

Over the next five years the PCT will improve access, choice and diversity through the Department of health contract for independent sector provision for diagnostics. It is also anticipated to extend the free choice regime through the addition of IS providers onto the Directory of Services.

In mental health services there is a range of independent and third sector providers who have been engaged in pre-tender discussions on provision of social inclusion services and it is planned to build on these relationships and to extend the number and type of providers in this area of health and social care.

In Learning Disability services the Social Care Change Programme will see the transfer of current resources invested in Surrey and Borders Partnership NHS Trust to independent not for profit, voluntary and private sector providers for the provision of residential care and group home living. The re-provision of the service will not lead to added pressures to NHS resources or on local NHS provisions, as clients already access the local health care professionals.

The table below indicates the financial impact over the life span of the CSP on the PCT's current main providers.

A high impact (H) relates to an impact on core contract values of more than £500,000 or 5%

A medium impact (M) relates to an impact on core contract values of between £250,000 to £500,000

A low impact (L) relates to an impact on core contract values of less than £250,000

	Mayday Healthcare NHS Trust	Community Health Services	Independent Contractors	South London and Maudsley NHS Trust	Others
G1.1 Children and young people	M	H	M		
G1.2 Smoking	L	H		L	L
G1.3 Healthy weights, healthy lives	L	M	M	L	H
G2.1 Long term conditions	H	H	H		
G2.2 Cancers	M	L	L		H
G3.1 Planned	H	L	H	L	H
G3.2 Urgent care	H	H	H	L	L

G3.3 GP led health centre and Primary Care Networks	H	H	H	L	L
G4.1 Maternity	H	L	L		L
G5.1 social care change programme					H
G6.Mental health				H	L
G7 Patient experience	Specific quality performance indicators will be negotiated in 2009/10 contracts that allow for the retention of ½ % of core contract value contingent upon meeting agreed standards.				

A more detailed assessment of the impact on secondary care providers of the Collaborative Commissioning Initiatives are set out in the CCI document.

SECTION 5 – DELIVERY

This section summarises the approach to delivery including the capabilities, the risks and the monitoring and management of delivery. The success of delivery of the Commissioning Strategy Plan will rely significantly on enabling strategies and these are also outlined.

5.1 Past delivery performance summary

Past delivery performance

Partnership Working

The Healthy Croydon Partnership was set up in 1999 to provide strategic leadership for health and social care in Croydon. It is one of eight theme partnerships which comprise the Local Strategic Partnership (LSP). It leads work across the LSP to improve health and tackle health inequalities. It is responsible for negotiating and delivering the health and well-being elements of Croydon's Local Area Agreement. It also produced the joint health improvement plan *Improving health and well-being: our plan for a healthy Croydon 2008-11*. The “impressive record in partnership working” was commended in the Improvement & Development Agency (IDeA) Healthy Communities Peer Review (April 2007).

Financial Control

The PCT has demonstrated a ‘Good’ for use of resources based on the Auditors’ Local Evaluation (ALE). Within this there has been some improvement on last year. The table below shows the themes reviewed as part of the Auditors’ Local Evaluation (ALE) assessment. An improvement was made within the Financial standing theme.

Overall score	Overall score	Financial reporting	Financial management	Financial standing	Internal control	Value for money
2007	3	3	3	3	2	3
2008	3	3	3	4	2	3

The PCT seeks to continuously improve its planning, forecasting and financial control. A weakness in previous years has been the slippage of project start dates. This led to the establishment of the Programme Management Office.

Programme Management Office

The Programme Management Office was established in September 2007 to strengthen the PCT’s programme and project management capacity and capabilities. The original remit was to manage key demand management and savings initiatives to ensure delivery of the Commissioning Strategy Plan. The process was extended during 2007/08 to manage all major initiatives within the Commissioning Strategy Plan and therefore also covered initiatives that required investment to improve health outcome (‘investment schemes’ – e.g. Smoking Cessation) and that dealt with the alternative provision of top class healthcare at reduced cost (‘efficiency schemes’ – e.g. Intermediate Minor Oral Surgery).

The approach enabled the PCT to successfully deliver a wide range of initiatives during 2007/2008 and is supporting delivery in 2008/09. The PCT’s demand

management and cash releasing efficiency savings initiatives achieved £6,972,000 against a target of £7,724,000 in 2007/08. In 2008/09 the scale of investment increased significantly and some initiatives have experienced significant slippage from the intended project start date. The PCT has taken this into account in identifying lead times and scheduling further projects more rigorously and strengthening its performance management.

Innovation and Redesign

Practice Based Commissioning is providing the opportunity to redesign clinical pathways based on current evidence, clinical guidance, quality standards and good practices in clinical service areas.

The PCT continues a systematic approach to reviewing existing care pathways and delivering new ones in order to improve quality of care and access to services and to secure better value. There are significant opportunities by building on these models to expand services offered, especially by community pharmacy and dentists, to support the improving health agenda, and to redesign services that will provide better models of care and quality of service for patients. Models of care will be based on current evidence, clinical guidance, quality standards and good practice in clinical service areas, including referral management and improvements to patient experience.

Practice Based Commissioning Groups are engaged to ensure primary care and community care is developed to support the 'front end' and 'back end' of the redesigned pathways and to therefore increase the range of services in primary care and to reduce unnecessary secondary care activity.

Managers are being supported in redesign through the commissioning of a targeted NVQ programme in priority areas.

The Healthcare Commission requires that healthcare organisations conform to NICE technology appraisals and, where it is available, take into account nationally agreed guidance when planning and delivering treatment and care. This generates significant patient benefits by providing protection from inappropriate interventions and resultant complications. It also leads to greater quality of care, better value for money and reduced unwarranted variation in the provision of care.

Building on this approach South West London Effective Commissioning Initiative (SWL ECI) provides a set of patient criteria to inform the commissioning of surgical interventions across the sector. They have been developed by the South West London Public Health Network. This initiative supports evidence based practice (as part of clinical governance) and a value for money approach to commissioning (reducing activity of limited or unproven benefits or of low priority). It is also intended to improve equity of access to healthcare across South West London PCTs.

In 2007/08 referrals into Secondary Care were reduced on grounds of clinical effectiveness in the following areas by the following percentages:

- tonsillectomies - target 40% achieved 36%
- grommets - target 50% achieved 30%
- varicose veins - target 12% achieved 16%

- hysterectomies - target 20% achieved 20%
- aesthetic surgery - target 15% achieved 5%

5.2 Capabilities summary

Last year's Commissioning Strategy Plan identified some key capacity and capabilities requiring development. During 2007/08 these have been addressed or are currently being implemented. For example:

- *Smoking* - Team capacity has been developed to work with different client groups and an interactive website is being developed
- *Long term conditions: Prevention, treatment, care* - Cross-sector workforce development is being extended and enhanced through the workforce strategy for nursing, allied health professionals and social care staff
- *Planned care*: Additional project management and implementation skills have been secured
- *Urgent care redesign* - External professional support has been sought to assist in the consultation process of both the urgent care and primary and community services strategies.
- *Maternity* – Project management and implementation skills have been secured
- *Financial surplus* - The establishment of the Programme Management Office increased the capacity for specialist financial and activity modelling and developing these skills among project leads.

As part of the refresh of the CSP goals and initiatives an initial assessment of the World Class Commissioning competencies has been undertaken, which has influenced the Organisational Development Plan. The detail of the capability requirements is included for each initiative within appendix 5. The main themes identified for development are:

- Using information including patient experience data.
Analysis and modelling of data, including interpreting health impact of interventions
- Staff skills and confidence in relation to patient and public involvement and consultation
- Development of workforce skills including stimulating the market and procurement

The Organisational Development Plan [will](#) enable the PCT to develop its internal and external capabilities to support improvement and innovation. The table below describes the developmental goals that are of particular importance for specific CSP goals and their link to WCC competencies. The skills and confidence of staff in relation to PPI and consultation are also addressed in the Communications Strategy and PPI Strategy.

	Organisational Developmental Goal	Commissioning Strategy Plan and Healthcare for London	WCC competency
1	Develop organisational values and behaviours to encourage and reinforce a culture which best enables us to achieve our strategic goals and objectives.	Core to our delivery of all the CSP goals. Of particular importance to our overall approach to improving our performance and delivery. Also important to goal 1 due to degree of partnership working, and equalities issues and to goal 7, as part of emphasis on improving patient experience	1,2,3,4,5,6,7,8,10
2	Systematically use information, including patient involvement and experience data, to support decision making and delivery.	Use of data systematically to drive decisions is key to achieving goal 7, as well as particularly important for goals with major redesign and procurement/market management issues, such as goal 3, and for developing an activity based approach in MH commissioning for goal 6. Will underpin our approach to addressing needs, prioritisation, linking goal to outcomes, securing delivery and measuring success	2,3,4,5 6,7,8,9,10
3	Develop a motivated and effective workforce, including career pathways, capable of delivering our strategic goals and objectives.	The skills of our workforce drive delivery of all our goals. However workforce capability development particularly key in goal 2, commissioning skills for LD and MH goals 5 and 6, and procurement skills in goal 3.	1,2,3,4,5 6,7,8,9,10
4	Work effectively with PCT's in SouthWest London, across London and with our Local Authority, to strengthen our capacity and capability through sharing and procuring.	The strengthening commissioning programme is particularly important for delivering the sector strategic goals set out in the CCI and London wide delivery of HfL set out primarily in Goal 2 (renal cancer), Goal 3 (stroke, trauma, paediatrics), Goal 4 (NICU, maternity) and Goal 6 (specialised mental health). SouthWest London Commissioning unit (acute) and pan-London business support agency. New role for PCT's re. intelligent client.	1,2,3,4, 6,7,8,9

5.3 Risk management summary

This summary risk assessment is based on the overall risks for the Commissioning Strategy Plan and a review of the themes from the individual risks within the initiatives. Details of the initiatives key risks and mitigating action are outlined in appendix 5.

The risks are grouped in three main themes:

- The risk of initiatives not having the expected impact
- The risks to implementation of the initiatives
- The risks from lack of interaction with stakeholders and partners

The Commissioning Strategy Plan is incorporated into the PCT Assurance Framework and the risks are incorporated into the PCT risk register. The risks have been scored using the established PCT risk assessment framework, with the severity being scored from 1 to 5 (1 being insignificant and 5 being catastrophic) and the likelihood also being scored from 1 to 5 (1 being rare and 5 being almost certain).

Before mitigating actions there are 3 high risk scores (H16 or above). These high risks are:

- PCT allocations less than assumptions
- Innovative approaches not proven to be effective
- Lack of buy in from stakeholders

Mitigating actions are in place for these and for the other identified risks as summarised in the table below. Financial risks and opportunities are provided in section 4.3.3 Impact on finance, and a full risk assessment is included within the 5 year financial plan. .

Risk	Severity	Likelihood	Risk	Mitigating actions	Severity	Likelihood	Residual Risk
Risk of initiatives not having expected impact:							
- Old ways of delivery are retained by organisations / individuals	4	3	M12	Consider and introduce new ways of working, supported by OD Plan	4	2	M8
- Poor financial / project modelling based on incorrect	5	3	M15	London Clinical Business Support Agency funded to	5	2	M10

Risk				Mitigating actions			
	Severity	Likelihood	Risk		Severity	Likelihood	Residual Risk
assumptions.				improve modelling			
- Poor quality of data and its interpretation	5	3	M15	Regular review of planning assumptions London Clinical and Business Support Agency funded to support improved data interpretation	5	2	M10
- Innovative approaches not proven to be effective	4	4	H16	OD Plan identifies skills to develop Regular reviews of impact and plans revised as necessary Pilot new approaches Ensure evidence based decision making	4	3	M12
Risks to implementation of initiatives:							
PCT allocations less than assumptions	5	4	H20	Slip developments. Increase demand management and/or savings. Increase programme/ project management. Reduce services if necessary	4	3	M12

Risk				Mitigating actions			
	Severity	Likelihood	Risk		Severity	Likelihood	Residual Risk
- Lack of local capacity, resources, capability	3	4	M12	<p>Explore alternative funding routes with partners</p> <p>Free resource from system savings</p> <p>Secure strategic framework for delivery</p> <p>Develop new staff roles, improve staff training and development and succession planning in line with OD Plan</p>	3	2	M6
- Inadequate Performance monitoring	4	3	M12	Develop performance monitoring tools and structure	3	2	M6
-Lack of Fair & transparent contracting/procurement in line with PCT guidelines	3	3	M9	<p>Develop comprehensive procurement policy, processes and procedures</p> <p>Use national contracts, legal advice where necessary and involvement of stakeholders</p>	3	2	M6
Interaction with stakeholders:							
- Lack of buy in to	4	4	H16	Effective	4	2	M8

Risk				Mitigating actions			
	Severity	Likelihood	Risk		Severity	Likelihood	Residual Risk
proposals due to diverse agendas, financial constraints and expectations				engagement and consultation processes, sharing learning and good practice Exploring new and innovative initiatives with stakeholders			

5.4 In-year monitoring and progress management summary

The PCT has a well established system of performance monitoring, progress management and assurance through a monthly performance meeting of the management team, with reports going through to the PEC and Board.

The PCT established a Programme Management Office in August 2007 led by a Programme Director to support and manage the performance of those initiatives which are key to the PCTs demand management and financial performance. It is ensuring more consistent use of robust financial and activity modelling, performance indicators, project management tools and reporting systems. The PCT also allocated specific resources for designated project managers.

The PCT is using this programme and project management approach to implement and monitor the Commissioning Strategy Plan. The initiatives in the Commissioning Strategy Plan will be a focus of organisational delivery as an integral part of the PCTs Operating Plan. As most of the initiatives are an extension of work the PCT is driving forward, specific monitoring and progress management arrangements are already in place. However the PCT will review these to ensure the over arching governance arrangements are sufficient for all the initiatives. Overall progress against implementation will be reported to Management Team on a monthly basis and reported to the Board through quarterly reports on the Operating Plan and the monthly finance reports.

To support performance improvement the Board has agreed to establish a non-executive led Performance Committee. Terms of reference are being developed and the first meeting is expected in January 2009.

Clinical panels have also been established to critique priority areas where performance improvement is not sufficient to critiques actions being taken to improve the following targets

The summary of the specific monitoring arrangements already in place is provided below, followed by a table setting out the specific performance trajectories against which the initiatives will be monitored.

Goal 1 Improving health and inequalities

Lead Director: Director of Public Health

Lead Assistant Director for Children and Young People Initiative: Assistant Director: Children's Partnership Commissioning

Lead Assistant Director for Smoking Initiative: Consultant in Public Health (Smoking)

Lead Assistant Director for Healthy Weight, Healthy Lives Initiative: Consultant in Public Health (Healthy Weight, Healthy Lives)

- Commissioning of the children and young people initiative is being undertaken in the context of the Children's Trust Commissioning Framework. Progress and performance will be reported to the Children and Young People's Strategic Partnership, and the Sexual Health Partnership Board, as well as through the PCT to the PCT Board.
- Progress on the smoking cessation action plan and performance against smoking cessation targets is reported and managed through the Management Team monthly performance reports and also through the Programme Management Office.
- Progress on the healthy weight, health lives initiative will be reported and managed through the Management Team monthly performance reports and as appropriate through the Programme Management Office

Goal 2 Long term conditions: Prevention, treatment, care

Lead Director: Director of Strategic Commissioning

Lead Assistant Director for Long Term Conditions Initiative: Long Term Conditions Project Manager

Lead Assistant Director for Cancer Initiative: Head of Acute Commissioning

- The Long Term Conditions Steering Group is a multi agency, director lead group which is responsible for the implementation of the initiative. It is accountable to the Healthy Croydon Partnership Groups and also reports to the Programme Management Office.
- The cancer initiative will be progressed through the East Locality Cancer Group (a local sub group of the Cancer Network) and progress will be reported to will be reported and managed through the Management Team monthly performance reports and, as appropriate through the Programme Management Office.

Goal 3 Care closer to home

Lead Director: Director of Primary Care Commissioning

Lead Assistant Director for Planned Care Initiative: Primary Care Commissioning Project Manager

Lead Assistant Director for Urgent Care Initiative: Project Lead - Urgent Care

Lead Assistant Director for GP Led Health Centre and Primary Care Networks Initiative: Primary Care Project Manager

- The Planned Care initiative is led through the PCT Commissioning Forum, supporting the Practice Based Commissioners, and report to the Programme Management Office.
- The urgent care redesign initiatives are monitored and managed through the Urgent Care Network and will report directly to the Programme Office.
- The GP led health centre will be managed through the project steering group and progress reported to Management Team and to the PCT Board.

Goal 4 Maternity: Quality, Access, Choice

Lead Director: Director of Strategic Commissioning

Lead Assistant Director for the Maternity Initiatives: Project Lead - Maternity Services

- The Maternity Services Liaison Committee monitors the implementation of the initiatives. Progress will be report to the Programme Management Office

Goal 5 Learning disability: Social Care Change Programme

Lead Director: Director of Strategic Commissioning

Lead Assistant Director for the Social Care Change Programme: Joint Commissioner - Learning Disability

- A project management structure is in place for the Social Care Change Programme. The Learning Disability Programme Board is accountable to the commissioning organisations as Project Sponsors through lead PCT and Local Authority representation.
- A Commissioning Group is responsible for management of the procurement process

Goal 6 Mental health and well-being

Lead Director: Director of Strategic Commissioning

Lead Assistant Director for Mental Health and Well- Being: Consultant in Public Health (Mental Health)

Lead Assistant Director for Mental Health Services: Assistant Director - Mental Health and Substance Misuse Partnership Commissioning

- The mental health initiative will be progressed through the mental health partnership group and progress will be reported and managed through the Management Team monthly performance reports and, as appropriate through the Programme Management Office.

Goal 7 Patient Experience

Lead Director: Director of Quality and Performance Improvement

Assistant Director Lead for Patient Improvement Initiative: Assistant Director for Quality and Patient and Public Improvement

- The patient experience initiative progress will be reported to will be reported and managed through the Management Team monthly performance reports and also through the Programme Management Office.

The table below sets out the specific performance trajectories against which the initiatives will be measured. Trajectories reflect the Operating Plan and LAA, and the arrows indicate desired direction of travel for that indicator.

Goal / Initiative	Total Non Recurrent Cost 2008/09 to 2012/13	Outcome	Baseline year and data	National baseline year and data	2008/09	2009/10	2010/11	2011/12	2012/13	Direction of travel	Current Priority
G 1.1 Children And Young People		Teenage conception	56.9 (2006)	40.6 (2006)	41.4	38.5	38.3	38.1	29.9	↓	WCC VSB08 LAA
		Immunisation for MMR (aged 2)	77.3% (2007/08)	84.6% (2007/08)	8.7	8.5	8.4	8.2	8.0	↑	WCC VSB10
		Immunisation: Diphtheria, Tetanus, Polio, Pertussis, Haemophilus influenzae type b (Hib) (Aged 1)			91%	92%	93%			↑	VSB10_03
		Immunisation:Pneumococcal infection (PCV) (Aged 2)			70%	80%	90%			↑	VSB10_08
		Immunisation: Haemophilus influenzae type b (Hib), meningitis C (MenC) - (Hib/MenC) (Aged 2)			50%	75%	90%			↑	VSB10_09
		Immunisation: Diphtheria, Tetanus, Polio, Pertussis (DTaP/IPV) (Aged 5)			70%	75%	80%			↑	VSB10_14
		Immunisation rate for children aged 5 who have been immunised for measles, mumps and rubella (MMR)			65%	70%	75%			↑	VSB10_15
		Immunisation: Human papilloma virus (Aged 12-13 years)			70%	80%	90%			↑	VSB10_18
		Immunisation rate for children aged 13 to 18 who have been immunised with a booster dose of tetanus, diphtheria and polio			75%	80%	90%			↑	VSB10_21
		Chlamydia prevalence (% 15 - 24 screened or tested for chlamydia)			15%	17%	19%			↑	VSB13_03
% protocols and plans in place covering access to CAMHS EI services			75%	75%	100%			↑	VSB12_04		
Healthy Schools		N/A		55%	65%	80%			↑	Local Vital Sign	
G 1.2 Smoking Cessation		Reduce smoking prevalence (Proxy measure: Smoking quitters)	345 (2006/07)	844 (2006/07)	649.2	665.2	706.3			↑	VSB05_03 LAA
		Reduce smoking in pregnant women	9.60%		9.60%	9.20%	9.00%			↓	Local Vital Sign
G 1.3 Healthy Weight Management		Childhood obesity: Percentage of children in Year R with height and weight recorded who are obese.	12% (2006/07)	9.9% (2006/07)	13%	13%	14%	14%	14%	↑	VSB09 LAA
		Childhood obesity: Percentage of children in Year 6 with height and weight recorded who are obese.			21%	22%	22%			↑	VSB09
G 2.1 Long Term Conditions		Reduction in emergency admissions (Non-elective G&A FFCEs, excluding well babies)			25606	25343	25083			↓	VSA05
		People with a long-term conditions feeling independent and in control of their condition (Proxy measure Reduction in emergency bed days)	212066 (200506)	n/a absolute no	183197	181365	179551			↓	VSC11
		Diabetes controlled blood sugar: Percentage of patients with diabetes who have an HbA1c of 7.5 or less	49% (2006/07)	60% (2006/07)	56%	58%	60%			↑	VSC27
		COPD: Deaths from bronchitis, emphysema and other chronic obstructive pulmonary disease (COPD) for all ages	30.6 (2004-06)	27.0 (2004-06)	28.9	27.2	25.5	23.8	22.1	↓	WCC
		Proportion of people achieving independence 3 months after entering care/ re-hab - rate per 10,000									↑
G 2.2 Cancers		Breast cancer screening: Coverage of women aged 53-64 by PCO (less than 3 years since last test)	70.6% (Mar 2007)	70.6% (Mar 2007)	71.7%	72.8%	73.8%	74.9%	76.0%	↑	WCC
		Breast Symptom Two Week Wait: %age of Patients referred for investigation/evaluation of breast symptoms and first seen within 2weeks (Year Extension of NHS Breast Screening Programme to women aged 47-49 and 71-73)			54%	100%	100%			↑	VSA08_03
		Extension of NHS Bowel Cancer Screening Programme to men and women aged up to 75.								↑	VSA09
		31-Day Standard for Subsequent Cancer Treatments (Chemotherapy and Surgery) : %age of patients receiving subsequent/adjuvant treatment within a			100%	100%	100%			→	VSA11_03
		31-Day Standard for Subsequent Cancer Treatments (Radiotherapy): %age of patients receiving subsequent/adjuvant radiotherapy treatment within a maximum			58%	82%	100%			↑	VSA12_03
		%age of patients receiving first definitive treatment within 62 days following referrals from NHS cancer screening service			100%	100%	100%			→	VSA13_03
		Cancer mortality rate (Mort rate 100k from cancer in people <75)	113.24 (2005)	120.15 (2005)	112.3	111.5	110.7			↑	VSB03_01

G 3.1 Planned Care	Reduction in secondary care activity									↓	
	- Reduction in first outpatient appointments	89,620		-4,484	-4,484	-4,484	-4,484	-4,484		↓	CSP
	-Reduction in follow up appointments	173,180		-8,658	-8,658	-8,658	-8,658	-8,658		↓	CSP
	- Reduction in total outpatient appointments	262,800		-13,142	-13,142	-13,142	-13,142	-13,142		↓	CSP
	% Admitted patients waiting <=18 wks	86% (Mar 2008)		90%	90%	90%				↑	
	% Non-admitted patients waiting <=18 wks	93% (Mar 2008)		95%	95%	95%				↑	
	Patients waiting 6 wks+ for all other diag tests			0	0	0				→	
	All 1st OP atts (cons led) in G&A specialties	97152 (2007/08)	n/a absolute no	97152	92289	87668				↑	VSA05_04
Total elective G&A day case FFCEs	35189 (2007/08)	n/a absolute no	33513	33088	32669				↑	VSA05_05	
Total elective G&A ordinary admission FFCEs	8965 (2007/08)	n/a absolute no	8460	8349	8239				↑	VSA05_07	
G 3.2 Urgent Care	Reduction in A&E attendances	111,767		123,225	129,387	135,856	142,649	149,781			CSP
	A&E 4 hour wait			98%	98%	98%				→	
G 3.3 GP Led Health Centre/ Primary Care	Patient reported measure of GP practice (Average of five elements of access to primary care)	84% (2007/08)	84% (2007/08)	84%	86%	87%				↑	VSA06
	Practices offering extended opening (% GP practices offering extended opening)			50%	55%	60%				↑	VSA07_03
G 4.1 Maternity	Low Birth weight: Percent of live and stillbirths where babies have weighed less than 2500grams	8.9% (2006)	7.9% (2006)	8.7	8.5	8.4	8.2	8.0		↓	WCC
	Women who have seen a midwife or a maternity healthcare professional, for health and social care assessment of needs,risk and choices by 12 completed weeks of pregnancy			50%	70%	90%				↑	VSB06_03 LAA
	Prevalence of Breastfeeding at 6-8 weeks			0.5	0.6	0.6				↑	VSB11_05 LAA
	Children with a breastfeeding status recorded as a percentage of all infants due for a 6-8 week check			85%	90%	95%				↑	VSB11_06 LAA
G 5.1 SSCP	Percentage of women giving birth at Mayday Birth Centre	19% (2007/08)		24%	30%	35%				↑	Local Vital Sign
	Transfer clients into new providers									↑	
G 6.1 and ^.2 Mental Health and wellbeing and Services	Develop or transfer residential homes to new providers			45	76					↑	Local Vital Sign
	Working age claimant rate			CHECK LAA?????						↑	LAA
G 7.1 Patient experience improvement	Working age people on out of work benefits			CHECK LAA?????						↑	LAA
	Self reported experience of patients and users: Patient experience score									↑	WCC VSAB15
	- Adult inpatient patient experience score (Acute Trust)	69.5 (2005/06)	76.2 (0506)	69.5	70.0	70.5				↑	WCC VSAB15
	- Adult outpatient patient experience score (Acute Trust)	72.5 (2004/05)	76.2 (0405)	72.5	73.0	73.5				↑	WCC VSAB15
	- A&E patient experience score (Acute Trust)	73.3 (2004/05)	74.3 (0405)	73.3	73.8	74.3				↑	WCC VSAB15
	- Patient experience score (Community mental health trust)	73.4 (2005/06)	74.6 (0506)	73.4	73.9	74.4				↑	WCC VSAB15
	- Patient experience score (PCT survey of primary care services)	75.0 (0405)	77.3 (0405)	75.1	76.0	77.0				↑	WCC VSAB15
	Average of five elements of access to primary care			84%	86%	87%				↑	VSA06
	Satisfaction with telephone access to GP practice (%)			89%	90%	91%				↑	VSA06
	Ability to see GP within 48 hours if wanted (%)			82%	84%	86%				↑	VSA06
	Ability to book GP consultation 3+ days ahead if wanted (%)			81%	82%	83%				↑	VSA06
	Ability to see a specific GP if wanted (%)			88%	89%	90%				↑	VSA06
	Satisfaction with GP practice opening times (%)			82%	84%	86%				↑	VSA06
	Choice: Percent of patients aware that they have a choice of hospital for their first hospital appointment			37%	46%	55%				↑	VSC16
	Choice: Percent of patients who went to the hospital they wanted, or had no preference			87%	91%	95%				↑	VSC16

		Acute and specialist hospital trusts									
		Respect and dignity: Overall, did you feel you were treated with respect and dignity while you were at the Outpatients Department? %			90.0	91.0	92.0			↑	VSC32
		Respect and dignity: Overall, did you feel you were treated with respect and dignity while you were in the Emergency Department? %			87.0	90.0	92.0			↑	VSC32
		Respect and dignity: Overall, did you feel you were treated with respect and dignity while you were in the hospital? %			84.0	88.0	92.0			↑	VSC32
		Mental health & learning disability trusts									
		Respect and dignity: Did the psychiatrist treat you with respect and dignity? % PCT (provider)								↑	VSC32
		Respect and dignity: Did the doctor treat you with respect and dignity? %			94.0	94.5	95.0			↑	VSC32
Total		Life expectancy at birth (years): Male	78.3 (2005-07)	77.7 (2005-07)	79.5	79.8	80.2	80.5	80.9	↑	WCC
		Life expectancy at birth (years): Female	82.0 (2005-07)	81.8 (2005-07)	82.1	82.2	82.3	82.4	82.5	↑	WCC
		Health inequalities: Average Index of Multiple Deprivation (IMD) score	21.31 (2007)	23.73 (2007)	Guidance required for trajectory setting					↓	WCC

5.5 Enabling strategies summary

To support delivery of the commissioning strategy plan, the PCT has a suite of enabling strategies which have just been finalised or are in development.

5.5.1 Strategic financial management to secure sustainable surplus

During the development of the first Commissioning Strategy Plan financial surplus had been identified as a goal. As part of the refresh of this document it was recognised that achieving a financial balance is now an enabling strategy, to support the delivery of the CSP goals.

The PCT delivered a surplus of £2.6m in 2007/08 and plans to deliver a £6m surplus in 2008/9, will receive £6.8m return of SHA lodgement and has £12.8 million of topslices still held NHS London. Over the lifetime of the Commissioning Strategy Plan the PCT will generate an on going surplus by bringing forward the 2008/9 year end surplus which will not be committed thus carrying forward a surplus over each and every year

The planned surplus will enable the PCT to ensure adverse financial risks can be met without the need for either reductions to services and quality or breaching the PCT's statutory duty to break even and to ensure the flexibility to facilitate change and to address future developments in Department of Health, NHS London and Healthcare Commission guidance and targets.

5.5.2 Market management and procurement strategy

The operating environment indicated by the Department of Health rules on contestability, the commissioning regime and the legislative environment provides the PCT with a new role in market management and market stewardship. This is defined as "managing the local markets that provide services to their residents". To support the PCT's role in market management the Board has agreed a strategic approach and framework.

The content of the Framework is derived from recent national guidance and is set within the context of the standards of practice expected within the World Class Commissioning programme. It builds upon the progress the PCT has already made in developing this role. For example initiative 5.1 Social Care Change Programme, which set out new specification of care for patients with learning disability and followed a formal invitation and full procurement processes, and formal tendering of GP lists and intermediate services.

To support this approach, there has been discussion across South West London (SWL) PCTs through the Collaborative Commissioning Initiatives group, the SWL Directors of Commissioning and other forums supporting the *Strengthening Commissioning* workstream. PCTs are developing and implementing arrangements to enable and sustain the contestability and procurement of clinical services. It is proposed that this approach should be based upon the following principles:

Principle 1: The PCT will contest the provision of all health services as and when the need or opportunity presents unless there is a robust rationale to consider alternative approaches

Principle 2: Any decision not to contest a service should be supported by clear and transparent evidence to demonstrate which of the “qualifying conditions” have been met in an individual case.

Principle 3: The PCT recognises its leadership role in the development of the local provider market and will prioritise increasing diversity of service provision to better ensure local access to a sustainable and expanding range of services appropriate to meet the needs of the local population.

Principle 4: The PCT will develop approaches that promote and support personalisation and choice for patients. The PCT will collaborate with other agencies to specify and procure services that address joint health and care needs where appropriate. The PCT will utilise patient experience feedback to influence the ongoing performance management of service providers and procurement decisions.

Principle 5: The PCT recognizes the model of “any willing qualified provider” for routine elective services.

The content of this strategic framework is derived from four areas of national and local guidance:

- The Standards for World Class Commissioning published by the Department of Health in December 2007
- Principles and rules for Cooperation & Competition published as an annex to the NHS Operation Framework for 2008/09.
- PCT Procurement Guide for Health Services published by the Department of Health in May 2008.
- The Commercial Strategy for London – Meeting the challenge of a reformed NHS – published by NHS London in November 2008
- Croydon Primary Care Trust Commissioning Principles – 2007 (see appendix 4)

As a practical first step to taking forward the strategic framework the PCT is reviewing its provider landscape as part of an assessment of current providers and service provision. Building on this provider analysis, the results of patient engagement, performance against national and local priorities the assessment will focus on:

- Access
- Choice
- Patient Experience
- Governance/Compliance – patient safety
- Value for Money
- Equalities and Diversity

This assessment will identify current weaknesses/gaps in our commissioned services which will require the PCT to iterate through service improvement, revised specification and – as appropriate – formal procurement to support improved performance and delivery of services to the population.

Any capacity or service gaps from this exercise will be prioritised along side the initiatives of the Commissioning Strategy Plan and will provide the PCT with a schedule of service requirements. Together this will inform a rolling procurement schedule for the life span of the CSP.

The PCT intends to conduct reviews of services provided and commissioned on a regular basis. The priorities for reviewing these services will be determined by a combination of service user, local population and other stakeholder feedback about their quality and perceived value. Service reviews may result in the need to procure new services.

Gaps in the overall supply chain for any given care pathway will be identified in order to further identify areas where market stimulation is required recognising that patients want seamless and efficient services, irrespective of the number of organisations involved in providing those services.

We aim to develop our role as market developers and lead the commissioning agenda. Croydon PCT will utilise opportunities through its market management approach that will ensure commissioned services are patient focused and deliver best possible health outcomes for Croydon residents.

This will ensure we commission services which:

- Achieve best possible health outcomes
- Reflect and meet the complex health and culture needs of the population
- Represent value for money
- Provide a high level of patient satisfaction

5.5.3 Organisational development plan

The Organisational Development Plan supports the delivery of the Commissioning Strategy Plan and its initiatives. The PCT will focus its efforts in addressing the capability gaps of the following four key developmental goals, which have been identified as potential barriers to the achievement of our CSP goals and strategic aim of becoming a world class commissioner.

1. Develop organisational values and behaviours to encourage and reinforce a culture which best enables us to achieve our strategic goals and objectives.
2. Systematically use information, including patient involvement and experience data, to support decision making and delivery.
3. Develop a motivated and effective workforce, including career pathways, capable of delivering our strategic goals and objectives.
4. Work effectively with PCT's in South West London, across London and with our Local Authority, to strengthen our capacity and capability through sharing and procuring.

5.5.4 Workforce strategy

The PCT has commissioned some work to develop a workforce strategy which is an important underpinning and enabling piece for the Organisational Development Plan and is reflected in the developmental goals. The first part of the work to inform our workforce strategy sets out the actions we need to take to ensure that we have a commissioning workforce capable of delivering the vision of world class

commissioning. The second part due for completion in early 2009 will enable us to develop the health and social care network we will need across Croydon in order to deliver our Commissioning Strategy Plan and meeting the aspirations of Healthcare for London and “Workforce for London – A Strategic Framework.”

The Workforce Strategy will achieve this aim, by helping us to more clearly define the roles that we need to develop and the specific capabilities associated with each of these roles. It will also identify individual developmental needs and outline a learning and development programme for addressing identified needs.

5.5.5 Communications Strategy

The Communications Strategy sets out how the PCT will use internal and external communications to support the delivery of our overall vision and strategic objectives. It complements the Patient and Public Involvement Strategy, and together they describe how effective communications and engagement will help us to:

- Support the delivery of the PCT’s overall strategy by providing information to people in Croydon to:
 - Help them improve their health
 - Inform them about the services available
 - Tell them how they can help shape services
 - Tell them how they have shaped services
- Raise the profile of the PCT to support its leadership role and effectively manage its reputation
- Ensure staff are fully informed and can be effective ambassadors for the organisation
- Ensure stakeholders are fully engaged in the work of the PCT and receive consistent messages
- Ensure that all PCT communications use clear language and format and are quality assured, including communications from commissioned and provided services.

The Strategy sets out the objectives and priorities for PCT communications focusing on implementation over the next three years. The seven key priority areas for development are:

- 1 Reputation – What are people saying about us?
- 2 Brand management
- 3 Quality and standards
- 4 Engagement and involvement
- 5 Use of marketing
- 6 Supporting performance and delivery
- 7 E-communications
- 8 Evidence based activities and evaluation.

5.5.6 Patient and public involvement strategy

The Patient and Public Involvement (PPI) Strategy – *1000s of everyday conversations* is about how the PCT makes sure that patients and the public have a real say in the commissioning, design and delivery of services. It sets out how we will embed the involvement and engagement of patients, carers and the public across the organisation and at each stage of commissioning. The strategy is an integral

part of our strategic approach to integrated communications and engagement and sets the direction for PPI work over the next one to three years based on a stocktake of current and recent activities and wide ranging discussions with internal and external stakeholders. The key areas for development are:

- Making sure involvement happens
- Supporting people to undertake high quality involvement
- Improving the way we use patient experience data
- Making sure we engage with people from all parts of society
- Working together with our partners
- Getting better at involvement in commissioning

The strategy is an integral part of delivering CSP goal 7 Patient Experience. Areas where we need to develop our capacity and capability to deliver the strategy are addressed in the Organisational Development Plan in particular as part of our work on organisational values and on systematic use of information, including patient involvement and experience data.

It also addresses getting better at involvement in directly provided services, which will be taken forward through the provider arm strategy.

5.5.7 Estates Strategy

The PCT is developing an Estates Strategy the aim of which is to move the primary and community estate to a position whereby it supports the delivery of 21st century health care and enables the delivery of services closer to where people are. The PCT is working in partnership with the council, South London & Maudesley Foundation Trust and Mayday Healthcare NHS Trust to take a strategic approach to overall estates needs of the borough.

The main challenges we currently face with the community and primary care estate in Croydon are as follows:

- The average age of the primary care estate is 59 years and extends up to 100 years
- Many of the buildings are not purpose built for health service delivery
- Many services are currently operating in cramped conditions
- Services have limited room to accommodate new/extended services
- The demand for extended services will mean that some of the estate will not be fit for purpose in the near future
- In some cases investment in current facilities will not resolve the building issues.

A survey of primary care and Community Health Service estates has been commissioned to evaluate, identify and help prioritise future developments. This will provide a robust baseline of the current estate and will include the following key areas:

- Physical Condition
- Statutory Compliance (inc. Health & Safety)
- Space Utilisation
- Functional Suitability
- Quality Audit

The estate strategy will be underpinned by businesses cases seeking funding, LIF T proposals and an engagement strategy for independent contractors who are providing services from their privately owned premises. The PCT is a key partner in three major capital projects which are in development:

- Croydon General – Work is ongoing with South London and Maudsley NHS Foundation Trust to develop a Children’s and Adult community rehabilitation and therapy centre. Both Trust’s Boards approved the Outline Business Case in October 2007 and a principal supplier has been selected to design and deliver the building.
- Parkway Health Centre – The PCT has been working with the Local Authority to replace the existing Parkway Health Centre. The new health centre will be located within a wider regeneration project, led by Croydon Council, and will include other key Local Authority services, include a sports centre and a library. A revised business case is being developed for the project.
- Purley Hospital – Work is underway with South London and Maudsley NHS Foundation Trust and Mayday NHS Trust to review the original service proposals for the scheme. A new Strategic Outline Case is being developed to take the project forward.

The PCT will be consulting in January to March 2009 on 6 hubs and primary care networks including one GP led health centre. It is expected that the GP led health centre will be open by March 2010, with 1 network to be established by March 2010/11, 2 networks to be established by March 2011/12 and the remaining 2 networks to be established by 2012/13.

5.5.8 IM&T Strategy

Historically, the PCT has piloted a number of National Programme for IT, now Connecting for Health, schemes relating to:

- Choose and Book
- GP2GP
- GP messaging
- Electronic Prescription Service

The strategy for IM&T at the PCT is based around the Connecting for Health (CfH) the national programme. In terms of IM&T progress the PCT is measured against the targets within the individual projects which comprise the programme. Some of these projects are applications in their own right and others support the development of the necessary infrastructure and operating principles necessary for a safe, secure and confidential environment into which the applications can be implemented. A draft plan was produced in May 2008 and feedback was received from NHS London CfH. The PCT will produce an IM&T Strategy, to be agreed by NHS London CFH, by March 2009.

In order to complete this strategy by March 2009, a working group has been established with representation for each directorate, and other representatives of the local health community (Mayday Hospital and LBC Social Services). The full strategy will detail of how the PCT plans overlap with other parts of the local health community.

The elements of the strategy will support:

- The full range of the London Programme for Information Technology (LPfIT) across the whole health community in addition to Local Implementation Strategy (LIS) legacy schemes and the Commissioning Strategy plan initiatives
- The management of the PCT IM&T Infrastructure, including all telephony services and NHSnet communications
- The delivery of information services to support all directorates, including commissioning.
- Support for provider services systems and provide information to support the provider SLA.
- The Department develops and maintains in house applications to support the achievement of corporate objectives

SECTION 6 – DECLARATION OF BOARD APPROVAL

The Croydon PCT Board started work on developing a longer term strategic vision and plan for the PCT in the autumn of 2006 and this work was built upon in the development of the Commissioning Strategy Plan during 2007. The outcome of the Healthcare for London consultation and the World Class Commissioning requirements has provided the opportunity for the Board to review its priorities and the impact of the changing landscape has been reflected in this revised Commissioning Strategy Plan.

The Board and the Professional Executive Committee have been fully engaged in the refresh of the Plan. Progress on the development of the Commissioning Strategy Plan was considered at the Board meetings in July, August, September and October 2008 and the Board provisionally agreed the proposed outcomes, goals and initiatives at the meeting in October 2008.

Resource requirements and initiatives identified within the Commissioning Strategy Plan will be incorporated into the PCT's Operating Plan and progress will be monitored and reviewed by the Board through quarterly reports on the Operating Plan, the monthly finance reports and the assurance framework. The focus of organisational activity on delivering the Commissioning Strategy Plan will be ensured through the Organisational Development Plan.

The Board recognises that clinical leadership is vital to delivering and continuing to develop the Commissioning Strategy Plan. The PCT has restructured the Professional Executive Committee to ensure this leadership is in place going forward, alongside the involvement of the Practice Based Commissioning Board. Engagement with patients, public and other stakeholders will continue across the range of initiatives and the PCT will undertake formal consultation for specific initiatives if required as these develop.

The full Commissioning Strategy Plan was considered and recommended for submission to NHS London at a Board seminar on 17 November 2008, subject to final amendments.

The Commissioning Strategy Plan was approved by Chair's Action on 27 November 2008. It will be reported to the public Board meeting on 16 December 2008. The Board will consider feedback from NHS London and the plan revised and agreed.